Oxford Pediatrics and Adolescents

5141 Morning Sun Road

Oxford, OH 45056

513-523-2156

James B. Davis, MD William Logeman, MD Sandra Flaishmakher, MD

Jill Mock, CPNP Sandy Simpson, CPNP

AUTHORIZATION FOR USE and/ or DISCLOSURE OF PROTECTED HEALTH

HEALTH INFORMATION

Patient Name and Date of Birth

_____

_____

Address_____

Phone Number_____

FROM:

Name of Facility_____

Address_____

Phone/Fax_____

TO:

Name of Facility_____

Address_____

Phone/Fax_____

You want records _____mailed _____you will pick up

Reason for request:

Moving out of the area:_____Changing physicians_____Legal_____Insurance_____

This authorization will expire in 60 days from the date listed below and is subje3ct to revocation by the parent/patient at any time prior to the expiration date except to the extent that action has been taken. I hereby state that I have read and fully understand the above statement as it applies to the named patient listed above. I hereby consent to the release of protected health information to the extent and for the purpose stated above. The release of all information is for the above patient's medical records with no limitations including information of psychiatric/psychological illnesses, alcohol and/or drug abuse, HIV test results and/or diagnosis treatment for HIV.

Authorization person's name and relationship to the above patient(s):

(Please Print)_____

Signature_____Date_____