Authorization to Release Medical Records

3330 Erie Ave Suite 11, Cincinnati, OH 45208
7720 Montgomery Rd 2nd floor, Cincinnati, OH 45236
PHONE: (513)321-0199 FAX: (513)979-0569
EMAIL: medrecords@hydeparkpeds.com

Patient Name: Date of Birth: _____

Patient Name: Date of Birth: _____

Patient Name: Date of Birth: _____ Address: Phone Number _____

City/State/Zip Code: _____

Date of Request: _____

☐ I authorize Hyde Park Pediatrics **to release information to*:**	**OR**	☐ I authorize Hyde Park Pediatrics **to obtain information from:**
Name: _____		Name: _____
Address: _____		Address: _____
City/State/Zip: _____		City/State/Zip: _____
Phone: (____) _____ Fax: (____) _____		Phone: (____) _____
Email: _____		Fax: (____) _____

Patient or Representative Signature _____Date_____

Printed Name _____Relationship to Patient_____

If transferring out of Hyde Park Pediatrics, please state reason for leaving:_____

*There is a $15 fee per child for records transferred OUT. The payment needs to be made before records are sent. Please call the office to make payment by phone or mail a check with the form.
Once this form is completed and received, please allow 2 weeks to complete the process.

Bill _____ PHO ____ Mgr _____ Med Records ____ Inactive____ Drop Down_____SP Status _____ Trfr Log _____

updated: 08-09-2024