



**Release of Protected Health Information from Previous Health Care Provider  
Authorization Form**

I hereby authorize the use or disclosure of protected health information about me/my child(ren)

\_\_\_\_\_ as described below.  
Patient's Name(s) (please print)

1. The Name of the person(s) or class of persons, authorized to make or use the disclosed is:

Name of previous Health Care Provider \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

2. The requested disclosure may be made to:

Senders Pediatrics  
2054 South Green Road  
South Euclid, Ohio 44121  
Phone: 216-291-9210  
Fax: 216-291-9422

3. Please release the entire medical and psychological records for the patient(s) mentioned above. If it is your policy to send only summary of illness, please note the dates of those illnesses and the medications used to treat them. In addition, please include complete growth chart and immunization records as these are very important in the evaluation of a child's health.
4. The information may be used or disclosed for the transfer of medical care.

\_\_\_\_\_  
Patient's Name(s) printed

\_\_\_\_\_  
Parent/Guardian's name printed

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Signature of patient or parent/guardian

\_\_\_\_\_  
Date