



**AUTHORIZATION FORM FOR THE
RELEASE OF MEDICAL INFORMATION**

Senders Pediatrics
2054 S. Green Road
South Euclid, OH 44121

Phone: (216) 291-9210
Fax: (216) 291-9422

Patient Name(s): _____
Please print

Date(s) of Birth: _____

Telephone #: _____

Current Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize Senders Pediatrics to release the health information indicated below that is contained in my, my child, or my children's patient records to the recipient named below. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. The authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization.

Name of Recipient: _____

Telephone #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Reason for disclosure: _____
Must complete before processing

Past Dates of Treatment: _____

- | | |
|--|---|
| <input type="checkbox"/> Emergency Department Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> History & Physicals (All) | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Other (please specify): _____ | |

This consent is subject to revocation at any time except to the extent that the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below. I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient may no longer be protected by law.

Signature of Patient/Patient's Personal Representative

Relationship to Patient

Printed Name

Date Signed



RELEASE OF MEDICAL INFORMATION (continued)

- Please indicate your preference:
- I would like to pick up the requested medical records.
 - I would like the requested medical records mailed to me at the address indicated at the top of the previous page.
 - I would like the requested medical records mailed to the recipient and address indicated in the middle of the previous page.

Fees: *(please read carefully)*

Medical records are provided on paper or compact disc. Please read this section then make your selection below. Medical records will be provided on compact disc if a preference is not specified. Please note: Medical records to be provided on a compact disc are free of charge. Medical records provided on paper are \$25. Medical records can be expedited in certain circumstances for a fee of \$15. If the patient(s) account holds a balance with our office the medical records will cost \$50. If a second copy of the medical records is being requested there is a fee of \$25. Fees for (any of the above) special requests will be due upon turning in this form. Fees only apply when the complete medical chart is being requested. If you are requesting a certain part of the medical chart only the records may be provided on paper.

Please see the attached page.

- Please indicate your preference:
- I would like the medical records on paper (\$25).
 - I would like the medical records on a disc.