

Patient's Request and Authorization for New Beginnings Pediatrics to Obtain Protected Health Information

I request and authorize

Name: _____

Address: _____

Telephone: (_____) _____

to provide a copy of the specific health and medical information as described below:

Patient Name: _____ DOB: _____

This Request applies to the following information to be provided one time, as soon as possible:
(select *only one* of the following)

All health information pertaining to any medical history, mental or physical condition and treatment received.
[Optional] Except: _____

Only the following records or types of health information (including any dates):

The designated information should be sent to New Beginnings Pediatrics, 282 Benedict Avenue Suite B, Norwalk, Ohio 44857. phone: (419) 668-9409 fax: (419) 668-4824 Attn. Dr. _____.

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Signature: _____
(Patient/Representative/Spouse/Financially Responsible Party)

Date: _____

If signed by someone other than the patient, state your legal relationship to the patient:¹

Witness: _____

¹ A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.