



## Muddy Creek Pediatrics

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### AUTHORIZATION FOR RELEASE AND CONSENT TO REQUEST MEDICAL RECORDS

I, \_\_\_\_\_ hereby authorize Muddy Creek Pediatrics, LLC and it's agents to release information regarding  
Parent or Guardian

\_\_\_\_\_  
Name of Patient and Date of Birth

(Check One)  Release to  Obtain from  Discuss with

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Release of information from this health record is for the purpose of (ie. transfer of records):  
\_\_\_\_\_

Reason for transfer: \_\_\_\_\_

Only pertinent information is to be obtained/forwarded/discussed and should include:

complete copy of records (\$15.00)

Other \_\_\_\_\_

SPECIAL AUTHORIZATION FOR RELEASE OF RECORDS FOR MENTAL HEALTH/REHABILITATION, ALCOHOL OR DRUG ABUSE AND/OR DEPENDENCY, HIV ANTIBODY TEST RESULTS AND/OR AIDS DIAGNOSIS AND TREATMENT.

Please initial all that apply, if the information is to be released.

Include information related to diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.

Include information related to diagnosis and/or treatment for mental health/rehabilitation.

Include information related to HIV antibody test results and/or AIDS diagnosis and treatment.

*I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information. I understand that this consent is revocable by me, in writing at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of this signature or automatically when the records/information requested on this form has been provided to the requestor.*

Date: \_\_\_\_\_ Signature of Patient or Patient Representative: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Witness: \_\_\_\_\_

**PROHIBITION OF REDISCLOSURE:** This information has been disclosed to you from the records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.