

**ANDERSON HILLS PEDIATRICS, INC.**  
**Eighteen & Older Release Form**

7400 Jager Court, Cincinnati, OH 45230  
(513) 232-8100 Fax (513) 624-3191

1126 Ohio Pike Amelia, Ohio 45102  
(513) 232-8100 Fax (513) 943-6154

**Please print your name, sign and date the form. You can mail or fax the form when complete, or bring into the office at your next appointment.**

**Description of "Protected Health Information" to be Used or Disclosed**

I understand that it is the policy of ANDERSON HILLS PEDIATRIC'S, INC. (the "Practice") to protect my privacy and to follow all state and federal privacy laws. However, I also understand that in order to **allow my parents to assist in my medical care** it will be necessary for the Practice to use/disclose some of my medical information ("Protected Health Information"), and, specifically, **health issues I encounter while under the care of this practice**. I understand that my Protected Health Information to be disclosed may include information regarding genetic testing, HIV / AIDS status, mental health diagnosis and treatment and substance abuse diagnosis and treatment, and I hereby specifically authorize the Practice to disclose such sensitive information to the persons listed below.

My Protected Health Information will be used / disclosed by the doctors, or the clinical and administrative staff of the Practice, for the purposes described above.

**Child's Rights**

I understand that I have the right to refuse to sign the Authorization to release my Protected Health Information. If I refuse to sign this Authorization, the Practice will in no way deny me my rights concerning treatment, payment for services, and enrollment in a health plan or eligibility for benefits.

I understand that I may revoke this Authorization at any time after I have signed it by providing Brian Vanderhorst, the Practice Manager, and the Practice's Privacy Officer, with a written statement that I wish to revoke this Authorization. My revocation of Authorization will be effective immediately and my Protected Health Information can no longer be used / disclosed pursuant to this Authorization except when **medically necessary**.

I specifically authorize this disclosure of my Protected Health Information as set forth in this Authorization. I understand that if my Protected Health Information is disclosed, then this information may be subject to redisclosure by the recipient and may no longer be protected by the federal patient privacy laws.

This Authorization, unless I earlier revoke it, shall remain in effect for **as long as I am an active patient at this practice**.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

**Check Disclosure below ONLY if Patient is for a Minor**

If this Authorization is signed by a legal representative of the patient (for example, the parent or legal guardian if the patient is a minor) a description of such representative's authority to act for the patient must also be provided (check applicable box and/or explain your authority to sign for the patient below). Except for legal representatives acting in the capacity as a parent to the patient, also attach a copy of documentation giving you the authority to sign this Authorization on behalf of the patient.

\_\_\_\_ Parent  
\_\_\_\_ Guardian  
\_\_\_\_ Power of Attorney

\_\_\_\_ Health Care Proxy or Surrogate  
\_\_\_\_ Executor or Administrator of Estate of Patient

Note: A copy of this signed Authorization must be provided to the individual signing the document.