



# NORTHWEST PEDIATRICS INC.

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## Record Transfer Request

Date of Request: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Children(s) Name: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Forward Records To:

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

### Reason for Record Transfer:

- Moving Out Of Area
- Insurance Coverage
- Age
- Convenience
- Location
- Other

If you marked other, please elaborate in order to help us better understand the needs of our patients:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize Northwest Pediatrics, Inc. to access or release the personal health information about my children as instructed above.

Parent Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**Other Information:**

1. I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
2. As described in the Notice of Privacy Practices, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Northwest Pediatrics, Inc. in reliance on this authorization, by sending a written revocation to Northwest Pediatrics, Inc., 7275 Sawmill Road, Dublin, Ohio 43016.
3. I understand that I am not required to sign this authorization form and that Northwest Pediatrics, Inc. will not condition the provision of treatment or payment to me on the signing of this authorization except that Northwest Pediatrics, Inc. may condition the provision of research related treatment to me on the signing of this authorization for the use of disclosure of personal health information for such research. Northwest Pediatrics, Inc. may also condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.
4. I understand that Northwest Pediatrics, Inc. is permitted by law to deny part or all of my request for access for one or more of the following reasons:
  - My access request form is not signed by me (the patient) or my representative;
  - My access request form is signed by representative but the representative has not provided information on the source of his/her authority to act on my behalf;
  - Northwest Pediatrics, Inc. does not maintain the information I have requested to copy or inspect;
  - The information I have requested is not part of our records;
  - My request is for psychotherapy notes;
  - My request includes information compiled for litigation.
5. The fee schedule as defined by Ohio law is as follows:
  - \$15.00 per person
  - \$25.00 per family

\_\_\_\_\_  
Name of personal representative, if applicable

\_\_\_\_\_  
Relationship of personal representative to patient or statement of personal authority

\_\_\_\_\_  
Signature of patient (or patient's representative)  
(If a verbal authorization, note this above and document who authorized)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Northwest Pediatrics, Inc. representative

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

**Verification of Identity**

Circle all means of verification as applicable

**In Person**

Driver's License or other government issued picture ID

If no picture ID, 3 forms of identification with name on them

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**In Writing**

Verified patient/parent information

Verified signature against documents already on file

**Over Phone**

- Billing address
- Patient's Date of Birth
- Mothers SSN
- Child's middle name
- Social Security #
- MR# or Account #
- Insurance ID
- Auditory/voice recognition