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## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release information from my medical records to:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The purpose of this request is for:

- Continuity of care
- Personal
- Legal matter
- Other (specify) \_\_\_\_\_
- Insurance claim

Information to be released:

- Face sheet with final diagnosis
- Discharge summary
- History and physical
- Consultation
- Surgery Report
- Pathology Report
- X-ray/Nuclear Scan/MRI Report
- Laboratory
- EKG
- Progress Notes
- Physician's Orders
- Nursing Notes
- ER Report
- Outpatient Report
- Summary of pertinent information
- Other \_\_\_\_\_

I understand that these records may contain information regarding care of psychiatric conditions, drug or alcohol abuse, HIV test results, AIDS and/or AIDS-related conditions.

Date of Treatment: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Name at Time of Treatment: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

*This authorization shall expire 60 days from the date of signing, and is subject to revocation by the patient at any time prior to the expiration date, but not made retroactive to any information already released pursuant to the authorization.*

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship, if other than patient \_\_\_\_\_ Witness \_\_\_\_\_

*This information has been disclosed from records whose confidentiality may be protected by State or Federal law. If applicable, State regulations (ORC 3701.243) and Federal regulations (42 CFR Pate 2) prohibit from making any further disclosure of this information except with the informed written consent of the person to who it pertains. A general authorization for release of information if held by another party is not sufficient for this purpose.*