627 S. Edwin C. Moses Blvd. Suite 2C, Dayton, Ohio-45417

Patient Authorization to Release Medical Information

Patient Name (Print)____**Patient DOB** _______________

I authorize (Physician's name) _________________________Phone # ____________ Fax # ______________

to release, and /or obtain my health information to Dayton Behavioral Care as described below.

Please identify the information to be released:

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):

- ☐ Assessment / Diagnostic Impression/lab Results
- ☐ Medication list
- ☐ List of allergies
- ☐ Progress in Treatment / Updates
- ☐ Most recent history and physical
- ☐ Most recent discharge summary
- ☐ X-ray and imaging reports (please describe the dates or types of x-rays or images you would like disclosed):
- ☐ Consultation reports (please supply doctors' names):
- ☐ Other (please describe):

Please initial each item below to indicate your understanding.

______ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

______ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The authorization will expire on (insert date or event):

____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

Signature of Patient / Guardian :_____________________________________ Date : __________________

Witness Signature ____ Date :________________