Authorization for Release of Dayton Children's Information

Patient Information	Last Name	First Name	Middle
	Address	City	State / Zip
	Birth Date	Other Possible Names	Phone #

Please select the box or boxes indicating which record(s) will be released/disclosed.

❑ Inpatient Records ❑ Abstract Date(s):	❑ Test Results Date(s):
❑ Almost Home Records ❑ Abstract Date(s):	❑ Radiology Reports ❑ CD of image Date(s):
❑ Emergency Department Records Date(s):	❑ Outpatient Clinic Records Date(s): Area:
❑ Operative Reports Date(s):	❑ Psychological/Psychiatric Date(s):
❑ Discharge Summary Date(s):	❑ Other Notes:

Please check the box indicating the method to receive copies of the records.

☐	Mail Copies **(Complete address in box below)**	☐	Pick up Copies **(Photo ID required)** Date:
☐	Review Only **(Photo ID required)** Date:	☐	Fax **(Patient Care Only)**

The following individual or organization is authorized to receive the information:			**The following individual or organization is authorized to make the disclosure:**		
Name Dayton Children's Hospital/ _____Dept.			*Name*		
Address One Children's Plaza			*Address*		
City Dayton	*State* Ohio	*Zip* 45404-1815	*City*	*State*	*Zip*
Phone #	*Fax #*		*Phone #*	*Fax #*	

Please check the box indicating the reason for the request. For medical treatment, please indicate the appointment date.

☐	Medical Treatment, **Date of appointment:** _____		
☐	Disability	☐	Legal
☐	Insurance	☐	School
☐	Other: _____		

I hereby authorize, Dayton Children's Hospital, to release and/or receive medical information, as indicated herein, to/from the above party. This authorization includes release of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions of the above-mentioned patient.

I understand that this authorization shall remain in effect for 1 year from the date of my signature below unless an earlier expiration date is specified in this space (_____). I also understand that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved.
I further agree that Dayton Children's may charge me or other designated recipients cost incurred in preparing the copy of the requested medical records. Dayton Children's will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this authorization.

I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Signature of Patient or Guardian	Date	
Relationship to Patient	Medical Record #	
Signature of Witness	Verification of Requestor ❑ By Signature ❑ By Photo ID	Copy given to Requestor? Y / N