Community Health Centers
of Greater Dayton

Office Use ONLY
Date Received:____________________________
Release Method:__________________________
Charge:___________________________________

Authorization for the Release of Information

IMPORTANT: Charges for this request may apply. Allow 7-10 business days for processing. Form must be HIPAA compliant and will not be processed if invalid.

I hereby grant my permission for the release or review of the following information concerning my health care.

Physician/Site Authorized to **Release** Information:
Name:____
Address:______________________________________
____
Phone/Fax:____________________________________

Physician/Site/Person Authorized to **Receive** Information:
Name:____
Address:______________________________________
____
Phone/Fax:____________________________________

For the purpose of: ☐ Self/Transfer of Care (charge may apply) ☐ Continuity of Care/Treatment ☐ Insurance Claim
☐ Legal Matter (specify) ______________________________ ☐ Other (specify) ________________________________

*Required

*Patient Name (include previous name):____

*Date of Birth:_________________________ Last 4 digits of Social Security Number:______________________

*Phone:_________________________ Address:____

Apt #:______________ City/State/Zip:____

Information to be Released:

☐ Demographic Sheet
☐ Chart Notes
☐ Laboratory Reports
☐ Pathology Reports
☐ Radiology Reports
☐ Consultations
☐ Operative Reports
☐ History & Physical
☐ ER Reports
☐ Immunizations
☐ Other (specify)_________________________________
____

Dates of Treatment:________________________________

I understand this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing below, I am specifically authorizing the release of this information:

☐ Drug/Alcohol Abuse Treatment
☐ Mental Health Records
☐ Psychotherapy Notes

____
Signature of Patient/Guardian Date

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be withdrawn at anytime in writing (see Notice of Privacy). This authorization will be effective for sixty (60) days after I sign and date the form below, unless I specify an earlier expiration date in the provided space:______________________

_____________ ____ ____
(Date) (Patient/Guardian/Representative Signature) (Witness)

☐HCPOA ☐Executor ☐Guardianship forms received

If the above signature is not the patients, explanation will be provided along with any necessary documentation.

☐ Minor ☐ Deceased ☐ Other (specify)____

Alex Central	Charles Drew	Corwin Nixon	East Dayton	Victor Cassano	Southview
(937) 247-0304	(937) 461-4336	(937) 228-0990	(937) 528-6850	(937) 558-0180	(937) 258-6330

Office Only: Copy given to patient: ☐ Yes ☐ No