# 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* | | | *Name* Dayton Children's Hospital/ _____Dept. | | |
| *Address* | | | *Address* One Children's Plaza | | |
| *City* | *State* | *Zip* | *City* Dayton | *State* Ohio | *Zip* 45404-1815 |
| *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, Children's Medical Center (Dayton Children's), 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<br>❑ By Signature<br>❑ By Photo ID | Copy given to Requestor?<br>Y / N |