



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.

<input type="checkbox"/> Inpatient Records	<input type="checkbox"/> Abstract	<input type="checkbox"/> Test Results
Date(s):		Date(s):
<input type="checkbox"/> Almost Home Records	<input type="checkbox"/> Abstract	<input type="checkbox"/> Radiology Reports <input type="checkbox"/> CD of image
Date(s):		Date(s):
<input type="checkbox"/> Emergency Department Records	<input type="checkbox"/> Outpatient Clinic Records	
Date(s):	Date(s):	Area:
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Psychological/Psychiatric	
Date(s):	Date(s):	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other	
Date(s):	Notes:	

Please check the box indicating the method to receive copies of the records.	<input type="checkbox"/> Mail Copies (Complete address in box below)	Pick up Copies (Photo ID required) Date:
	<input type="checkbox"/> Review Only (Photo ID required) Date:	Fax (Patient Care Only)

The following individual or organization is authorized to receive the information: Name _____ Address _____ City _____ State _____ Zip _____ Phone # _____ Fax # _____			The following individual or organization is authorized to make the disclosure: Name Dayton Children's Hospital/ _____ Dept. Address One Children's Plaza City Dayton State Ohio Zip 45404-1815 Phone # _____ Fax # _____		
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Please check the box indicating the reason for the request. For medical treatment, please indicate the appointment date.	<input type="checkbox"/> Medical Treatment, Date of appointment: _____	
	<input type="checkbox"/> Disability	<input type="checkbox"/> Legal
	<input type="checkbox"/> Insurance	<input type="checkbox"/> School
	<input type="checkbox"/> 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 <input type="checkbox"/> By Signature <input type="checkbox"/> By Photo ID	Copy given to Requestor? Y / N