AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

☐ DOC Pain Management
☐ Miami Valley Ambulatory Surgery Center
☐ DOC Vein Management
☐ Miami Valley Urgent Care
* In Association with AccessMD Urgent Care
☐ DOC Imaging Services

I, the below identified person, do hereby authorize the release of my protected health information, as indicated herein, between the following parties:

From: Dayton Outpatient Center
1010 Woodman Dr.
Dayton, OH 45432

To : ______________________________________
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FAX #______________________________________

I authorize the use or disclosure of the following protected health information; records: **(Please list dates of service, condition or event you wish to have records released for)**

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I am requesting that these records be released for the following purpose:

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I authorize that this authorization shall remain in effect for _______ days from the date of my signature below. If not specified, this authorization shall be in effect for 1 year. I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time. I understand that the revocation is not effective to the extent that the provider has relied on the use or disclosure of protected health information. I understand that information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the HIPAA rule.

I am also making the following additional qualification: If the information specified above contains information related to treatment for drug and/ or alcohol abuse or HIV test results or diagnosis, I am including this type of information to be released in association with this authorization.

I understand that I have the right to inspect or copy my protected health information to be used or disclosed as permitted under federal or state law and that I have the right to refuse to sign this authorization.

________________	______________________________________	____________________________
Date	Patient or Personal representative (Guardian) Signature	Description of Personal Rep. Authority
________________	______________________________	____________________________
Date of Birth	Print Patient Name	Social Security Number

Reason patient is unable to sign:

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Medical record requests can be made by emailing a medical request form to **medicalrecords@daytondoc.com** or fax to **833-471-6179**.