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 Date(s):	❑ Abstract/Summary	❑ Test Results Date(s):	
❑ Inpatient Records Date(s):	❑ Entire legal (includes nursing flowsheets)	❑ Radiology Reports Date(s):	❑ CD of image
❑ Emergency Department Records Date(s):		❑ Outpatient Clinic Records Date(s):	Area:
❑ Operative Reports Date(s):		❑ Psychological/Psychiatric Date(s):	
❑ Discharge Summary Date(s):		❑ List of visit dates	
❑ Well Child/Immunizations Date(s):		❑ Other Notes:	

Select a Format for Delivery	❑ Paper - Mail **(Complete address in box below)**	❑ CD – Mail **(Complete address in box below)**	❑ Flash Drive – Mail **(Complete address in box below)**	
	❑ Fax **(List # in box below)**	❑ My Kids Chart	❑ E-mail ***(See statement directly below)**	

******If you select the e-mail option, you hereby acknowledge and accept the inherent risk associated with an unsecured e-mail transmission, which can place your information at risk of being read or accessed by someone else, and you agree that Dayton Children's Hospital will not be responsible for disclosures that might occur in transit.***

The following individual or organization is authorized to receive the information:			
Name			
Address		*E-mail address*	
City	*State Zip*	*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 medical information, as indicated herein, to 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 (document on file) ❑ By Photo ID ❑ Info in System	Record copy given to Requestor by Clinic or Radiology Y / N