

# Authorization for Release of Dayton Children's Information

<b>Patient Information</b>	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/Summary	<input type="checkbox"/> Test Results
Date(s):	Date(s):	
<input type="checkbox"/> Inpatient Records	<input type="checkbox"/> Entire legal (includes nursing flowsheets)	<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"/> List of visit dates	
Date(s):		
<input type="checkbox"/> Well Child/Immunizations	<input type="checkbox"/> Other	
Date(s):	Notes:	

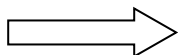
<b>Select a Format for Delivery</b>	<input type="checkbox"/> Paper - Mail (Complete address in box below)	<input type="checkbox"/> CD – Mail (Complete address in box below)	<input type="checkbox"/> Flash Drive – Mail (Complete address in box below)
	<input type="checkbox"/> Fax (List # in box below)	<input type="checkbox"/> My Kids Chart	<input type="checkbox"/> 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		E-mail address	
Address			
City	State	Zip	Phone
		Fax	

**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"/>	Insurance
<input type="checkbox"/>	Legal
<input type="checkbox"/>	School
<input type="checkbox"/>	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 <input type="checkbox"/> By Signature (document on file) <input type="checkbox"/> By Photo ID <input type="checkbox"/> Info in System	Record copy given to Requestor by Clinic or Radiology Y / N