DAYTON
INTERNAL MEDICINE

Progressive Medicine. Compassionate Care.

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Authorization for Release of Medical Records

Dayton Internal Medicine is a Hipaa-compliant office.

Patient Info

Patient Name:_____Date of Birth:_____

Address:_____Phone:_____

Facility to Release Medical Records

Name:_____Phone:_____

Address_____Fax:_____

City:_____State:_____ZIP:_____

Dates and Type of Information to Disclose

- O Office Notes
- O Imaging Reports
- O Hospital Discharge
- O Pathology Report
- O Lab Results
- O Hospital Stay
- O Immunization Records
- O Operative Report
- O Specific Information Requested:_____
- O Specific Dates Requested:_____

THE PURPOSE OF THIS DSICLOSURE IS FOR CONTINUATION OF CARE. I authorize to release or disclose to the above named facility all my medical records, including and special protected medical records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment. I understand that I may revoke this authorization at any time in writing. However, I also understand that any release which has been made prior to my revocation and which was made on the basis of this authorization shall not constitute a Branch of Confidentiality. I understand that my records are protected under the federal law regulations 42, CFR Part 2, HIPAA, and TCA 33 and cannot be disclosed without my written consent unless otherwise provided by these regulations. This authorization will automatically expire within 12 months if no date is indicated below. I understand that treatment, payment, enrollment, or eligibility benefits will not be conditioned on signing this authorization, and that there are no consequence to me if I refuse to sign this authorization. I understand that once this information is used or disclosed it may be subject to redisclosure and may no longer be protected except as required by federal law.

_____ _____

Signature of Patient or Representative Date