DCND
Dayton Center for
Neurological Disorders

1975 Miamisburg-Centerville Rd.
Centerville, OH 45459
Phone: 937-439-6186
Fax: 937-439-6189

# Authorization to Disclose Protected Health Information

| RELEASE INFORMATION FROM: | RELEASE TO (where PHI is going): |
|---|---|
| Organization Name: ________________ | Organization Name: ________________ |
| Address: ________________<br>________________<br>________________ | Address: ________________<br>________________<br>________________ |

I authorize my health care provider to disclose my protected health information:

Patient's full name ______________________________

Maiden or other name ______________________________

Date of birth ________________ SSN/Medical Record # ________________

Address ______________________________

______________________________

Covering the period of health care from ______/______/____ to ______/_______/_______

Information authorized for disclosure (if in my record):

- ☐ Complete health record
- ☐ Visit/discharge summary
- ☐ Clinical documentation of physical
- ☐ Documentation of consultation
- ☐ Immunization record
- ☐ Progress reports
- ☐ Radiology and diagnostic imagining reports
- ☐ Photographs, videos or other images
- ☐ Lab tests
- ☐ Other ________________

Additional sensitive protected health information I wish to be released:

- ☐ AIDS or HIV
- ☐ Behavioral Health Services/Psychiatric care
- ☐ Treatment for alcohol and/or drug abuse
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Genetic counseling/testing
- ☐ Other ________________
- ☐

__________ I understand the information disclosed according to this authorization, except information protected by federal
Initial and/or state regulations, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other laws.

I understand I have the right to revoke this authorization at any time but I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation does not apply to information already released. Unless otherwise revoked, this authorization will expire on the following date _____/_____/____ or unlimited as initialed here ______. If I fail to specify an expiration date, this will expire in 90 days. It is the responsibility of the patient to notify DCND of any changes to guardianship or life changes so documentation is given. I understand that any disclosure of health information comes with the potential for unauthorized and future re-disclosure as allowed by HIPAA and other federal privacy rules. DCND, its employees, officers and physicians are hereby released from any legal responsibility or liability in disclosing the above information to the extent indicated on this form.

______________________________________________ Date ____________
(Signature of patient or legal representative or guardian) (Relationship to patient)

______________________________________________ Date ____________
Witness or Notary (this form must be notarized if information is being released to an attorney or court)