AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Dayton Physicians Network to release the following information

☐ Medical Information ☐ Billing Information

Persons To Whom Information May Be Disclosed (exclude treating physicians)

Information described above may be disclosed to:

Name of person or organization Relationship Phone #

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Name of person or organization Relationship Phone #

If you have an answering machine or voice mail at home or cell phone, may we leave a message?

☐ Yes ☐ No If Yes: Home Phone # ____________________ Cell Phone # ____________________

If you have voice mail at work, may we leave a message for you to return our call (note: private information will not be left on your voice mail, only the message to return our call)?

☐ Yes ☐ No If Yes: Work Phone # ____________________

If we call your home and you are not available, may we leave information with the authorized person?

☐ Yes ☐ No

Written Communication

☐ Mail to my home address ____________________

☐ Mail to my work address ____________________

☐ Fax to this number ____________________

☐ E-mail to this address ____________________

Right to Terminate or Revoke Authorization

This authorization is effective unless revoked or terminated by the patient or the patient's personal representative.

You may revoke or terminate this authorization by submitting a written request to Dayton Physicians Network.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Act.

Signature

Name of patient (Print or Type)

Signature of Patient Date

Name of Patient Representative (Print or Type)

Signature of Patient Representative Date