



2621 Dryden Road  
Suite 202  
Dayton, OH 45439

For Office Use Only: Fee Collected: \_\_\_\_\_  
 Identification Presented: \_\_\_\_\_  
 Date Received: \_\_\_\_\_ By (Initials): \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Patient's Social Security #: \_\_\_\_\_

**Provider/Agency/Individual RELEASING Records:**

Name/Organization: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Provider/Agency/Individual RECEIVING Records:**

Name/Organization: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Information May Be:  Faxed  Mailed  Reviewed Only  Discussed via telephone  In Person Meeting  
 Verbal Communication only (no records needed)

I authorize release *except for the following stipulations:* \_\_\_\_\_

<b>Information to be released:</b>	<b>Dates of Treatment:</b> _____
_____ Copies of basic information (face sheet discharge summary, H&P)	_____ Consultations
_____ Copies of pertinent information (basic information and test results)	_____ Copies of Neuropsychological Evaluation(s)
_____ Discharge summary/face sheet only	_____ Progress Notes
_____ Other (specify): _____	

Purpose of Information Requested:  Continuity of Care  Legal  Insurance  Personal  
 Other (Specify) \_\_\_\_\_

I hereby authorize The Flexman Clinic to release and/or receive medical information, as indicated herein, to/from 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 will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
- I understand that I may revoke this authorization at any time by notifying The Flexman Clinic at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken to reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- My health care and payment for my health care will not be affected if I do not sign this form.
- I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
- I understand that I will get a copy of this form after I sign it.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
RELATIONSHIP TO PATIENT