HIPAA 3.01

SDACC Patient Authorization

For

USE, DISCLOSURE, TRANSFER OR RELEASE

Of the Patient Protected Health Information

This authorization is used for patient request, SDACC practice requests, other physician practice requests, research, laboratories, pharmacies or other entities listed below.

By signing this authorization, I authorize **South Dayton Acute Care Consultants, Inc.** to use, release, disclose and/or transfer certain protected health information about me and/or copies of my protected health information from my medical records, with no limitations. This authorizes release of all information, not specifically excluded below, concerning treatment of drug and/or alcohol abuse, drug-related conditions, alcoholism, psychiatric/ psychological conditions, HIV disease, HIV testing and results and/or diagnosis /treatment of AIDS or AIDS related treatment.

I further authorize that this information may be faxed, so long as reasonable efforts are made to keep confidentiality of such information in the course of transmission.

The information to be used or disclosed may include, but is not limited to: *(Please check all that apply)*

Copy of Entire Record ____**Face Sheet/Demographics**
____**History and Physical** ____**Laboratory/Pathology/Radiology Reports**
____**Discharge Summary** ____**Operative Reports/Emergency Room Treatments**
____**Consultation(s)** ____**Progress Notes/Clinical Notes**
____**Medication Records** ____**Other (Please Specify)**________________________

Please do not release information concerning:________________________

To assist in identification and location of my records, I am providing the following information:

Patient Name used when treated: ________________________

Date of Birth: ____________ Social Security Number:________________________

Treatment Dates: ________________________

Purpose for use, transfer, disclosure or release: ________________________

This information is to be released:

From: ________________________ To: ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

>>> This authorization expiration date is 1 year from signed authorization date, unless the authorization is revoked by patient or otherwise defined by patient or event.

>>> A Photocopy of this authorization is to be accepted the same as the original.

I understand I do not have to sign this authorization in order to receive treatment from South Dayton Acute Care Consultants, Inc. In fact, I have a right to refuse to sign this authorization. I also have the right to inspect or copy the information to be used or disclosed. I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Eileen Pape, RN, Compliance Officer or Luann Miller, RN, Clinical Nurse Manager at South Dayton Acute Care Consultants, Inc., 33 West Rahn Rd, Suite 101, Dayton, Ohio 45429.** I understand that a revocation is not effective to the extent that South Dayton Acute Care Consultants, Inc. has relied on the use or disclosure of the protected health information. I further understand that my information used or disclosed in accordance to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I hereby state that I have read and fully understand the above statements as they apply to the named patient. I hereby consent to the use/disclosure of the above named patients protected health information.

Print Name of Patient or Legal Guardian*. ________________________

Signature of Patient or Legal Guardian*: ________________________

*If not patient, relationship to Patient: ________________________

Date: ________________ Witness: ________________________