SDACC Patient Authorization
For
USE, DISCLOSURE, TRANSFER OR RELEASE
Of the Patient Protected Health Information

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. This authorization applies to all information, not specifically excluded below, including treatment of drug and/or alcohol abuse, psychiatric/ psychological conditions, HIV disease, HIV testing and results and/or diagnosis /treatment of AIDS or AIDS related treatment.

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 sooner revoked by patient.**

⇒ **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 **SDACC's Compliance Officer or 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 authorization to use or disclose protected health information. I further understand that my information used or disclosed in accordance with 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 patient's protected health information.

Print Name of Patient or Legal Guardian*: ____

Signature of Patient or Legal Guardian*: ____

*If not patient, relationship to Patient: ____

Date: ____________________________ Witness: ____

743128.2