Dayton RESPIRATORY Center

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STAFFED OFFICES

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F: (937) 832-7323

7415 Brandt Pike
Huber Heights, OH 45424
P: (937) 610-3800
F: (937) 610-4680

7056 Corporate Way
Centerville, OH 45459
P: (937) 312-9144
F: (937) 312-9146

200 Medical Center Dr., Ste 290
Middletown, OH 45005
P: (513) 857-3301
F: (937) 949-6100

SATELLITE OFFICES

1244 Meadow Bridge Dr.
Beavercreek, OH 45434

700 S. Stanfield Rd.
Troy, OH 45373

1671 North Limestone St.
Springfield, OH 45502

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I hereby authorize Dayton Respiratory Center to receive and/or give information regarding my condition/treatment to achieve the important goal of increasing the safety and effectiveness of my treatment.

Name _____ **DOB**_____

Last 4 of social _____

Release the information to: _____

_____

Receive from : _____

_____

CIRCLE ALL THAT APPLY:

FULL TREATMENT SUMMARY **COMPLETE COPY OF RECORDS**

DEMOGRAPHIC/INSURANCE INFORMATION

X RAYS/LABS **MEDICATION LISTS** **SLEEP RECORDS**

This authorization shall be in force from: **Start** _____ **End** _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification at the address above, except to the extent that the information has already been released in reliance to this form.

I understand the information used or disclosed pursuant to this authorization, may be subject to redisclosure by the recipient, and may no longer be protected by federal or state law.

I understand that I had the right to inspect or copy the protected health information that is used, or disclosed as permitted under federal law, and I can refuse to sign this authorization.

Date: _____ **Signature**: _____