



AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Dayton Physicians, LLC – Urology Division to release the following information:

- Medical Information Billing Information

Persons To Whom Information May Be Disclosed

Information described above may be disclosed to:

Table with 3 columns: 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

- OK to mail to my home address _____
- OK to mail to my work address _____
- OK to fax to this number _____
- OK to 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, LLC – Urology Division

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

Signature of Patient Representative

Relationship of Patient Representative to Patient