

Orthopaedic Institute of Dayton

3205 Woodman Drive, Dayton, Ohio 45420

Phone: (937)298-4417 Fax: (937)298-8260

Authorization for release of protected health information

Please allow 7-10 Business days for your request to be processed

Patient Name: _____ DOB: _____

PHONE #'s: _____

Protected health information is being released for the purpose of:

MEDICAL RECORDS FROM OID RELEASED TO:	MEDICAL RECORDS TO OID RELEASED FROM:	
Name: _____	Name: _____	
Address: _____	Address: _____	
City/State/Zip: _____	City/State/Zip: _____	
Phone #: _____	Phone: _____	
Fax #: _____	Fax #: _____	
MEDICAL RECORDS <input type="checkbox"/>	XRAYS <input type="checkbox"/>	MRI DISC <input type="checkbox"/>
Physician: _____	Body Part: _____	
Comments: _____		

DISABILITY/FMLA FORM <input type="checkbox"/>	FAMILY/SPOUSE FMLA FORM <input type="checkbox"/>
Company _____	
Attn: _____	
Address: _____	
Phone #: _____	Fax #: _____
Disability Start Date _____	Return to Work Date _____

FEES: There is a **\$25.00 processing fee** per set of disability/FMLA forms and for any updates. There is also a **processing fee for copies of medical records and x-rays**. Fees are based upon records requested and the volume of your file. This fee can be paid at drop off or pick up of form or by credit card over the phone. This is payable by you to OID an payment may be made via check, money order, cash, or credit card.

P/UP CALL TO PAY PER PHONE (MAIL OR FAX RECORDS) MAIL INVOICE

This authorization shall be in effect for one (1) year.

I understand I have the right to revoke this authorization at anytime by sending written notification to Pam Hough at OID Inc. I understand that information released by use of 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 have the right to inspect or copy the protected health information to be released as permitted under federal law. I understand I have the right to refuse to sign this authorization. I understand I have the right to receive a copy of the signed authorization.

SIGNATURE X _____ DATE _____

*****OFFICE STAFF USE ONLY *****

ACCOUNT# _____ Doctor _____
DATE RECEIVED _____ INITIALS _____ PAID _____