



**Good Samaritan Hospital**

2222 Philadelphia Drive  
Dayton, Ohio 45406  
Phone (937) 278-2612

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**IMPORTANT - PLEASE READ:**

**Charges for this request may apply. Allow 7-10 business days for processing.**

**All requests will be mailed unless other arrangements are specified.**

I hereby grant my permission for release or review of the following information relating to my care from and to the parties named here.

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The purpose of this request is for:

- Continuity of care       Legal matter       Other (specify) \_\_\_\_\_  
 Insurance claim       At the request of the individual

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name at time of treatment

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Patient's Address

\_\_\_\_\_  
Telephone Number

Date of treatment(s) \_\_\_\_\_

This information MAY include treatment or rehabilitation for drug and/or alcohol abuse, psychiatric treatment, HIV Antibody Test (test for AIDS Virus) or AIDS and related conditions, IF they did occur. I specify that this release is to include:

- |                                                   |                                                         |                                                      |
|---------------------------------------------------|---------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Face Sheet               | <input type="checkbox"/> Laboratory Report              | <input type="checkbox"/> Mental Health Treatment     |
| <input type="checkbox"/> Discharge Summary        | <input type="checkbox"/> Radiological Reports           | <input type="checkbox"/> Other specified here: _____ |
| <input type="checkbox"/> History & Physical       | <input type="checkbox"/> Operative Reports              | _____                                                |
| <input type="checkbox"/> Consultation             | <input type="checkbox"/> Pathology Reports              | _____                                                |
| <input type="checkbox"/> Emergency Room Treatment | <input type="checkbox"/> Drug / Alcohol Abuse Treatment | _____                                                |

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be withdrawn at any time in writing (see Notice of Privacy). This authorization will be in effect for 60 days after I sign and date the form below unless I specify an earlier expiration date in this space \_\_\_\_\_.

\_\_\_\_\_  
Date                      Signature                      Witness                      Date

- HCPOA       Executor       Guardianship forms received

If the above signature is not that of the patient, explanation will be provided below and documentary evidence of appropriate papers shall be required to accompany this authorization. \_\_\_\_\_