Over 10 years of caring
Dayton Physicians Network
Cancer Care and Urology

# AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Dayton Physicians Network to release the following information

☐ Medical Information ☐ Billing Information

**Persons To Whom Information May Be Disclosed (exclude treating physicians)**

Information described above may be disclosed to:

_____

Name of person or organization Relationship Phone #

_____

Name of person or organization Relationship Phone #

_____

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**

☐ Mail to my home address _____

☐ Mail to my work address _____

☐ Fax to this number _____

☐ 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 Network.

**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

_____

Name of Patient Representative (Print or Type)

_____

Signature of Patient Representative Date