Nephrology Associates of Dayton, Inc.
7700 Washington Village Drive, Suite 230
Dayton, Ohio 454529
Phone: 937-438-3132 Fax 937-438-8707

Authorization for Release of Medical Records

I hereby grant my permission for release of any medical information between the following parties, with no limitations. This authorization includes any information concerning treatment for psychiatric illness, alcohol and/or drug abuse, sexually transmitted disease information, and HIV/AIDS information.

Records From: ______________________ Send To: ____________________________
______________________ ____________________________
______________________ ____________________________

I direct that all information obtained in association with this release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific authorization. I understand that this Authorization is voluntary and that I may refuse to sign it; my refusal to sign will not affect my ability to obtain treatment. I understand that this Authorization shall remain in effect for ninety (90) days from the date of my signature unless I specify an earlier expiration date in this space_____________. I understand that, except to the extent that action has been taken based on my authorization, I may withdraw this Authorization at any time by written notification to the parties involved. This Authorization in no way negates the ability of the above named practice to carry out any communication that may be necessary for patient continuity of care with another provider; nor does it replace the Nephrology Associates of Dayton, Inc. HIPAA Form (Patient Consent for Use and Disclosure of Protected Health Information).

Information Requested

_____Copy of Record from __________ to ________________

__ Copy of Entire Record
__History and Physical
__Laboratory/Pathology Reports
__X-ray/CT scans/Ultrasounds
__Operative Reports
__Nursing Notes
__Consultation Reports
__Emergency Room Records
__Progress Notes
__Physician Orders
__EKG/Stress Tests
___________________Other: (Specify)

Reason for Transfer: (Please select one)

___NAOD Physician Referred to Specialist
___Selecting New Physician
___Other – Please specify _____________________________
_____Patient Request (personal use)
_____Third Party Request (attorney, insurance, etc.)

I understand that unless I specify a timeframe, 2 years of my past history will be sent to the designee. Initial here: _______

For questions regarding Medical Records contact Nephrology Associates of Dayton, Inc. at 937-312-6531.

ATTENTION NEW PATIENTS OF NEPHROLOGY ASSOCIATES OF DAYTON, INC. ** NEW PATIENT MEDICAL RECORDS MUST BE FAXED TO (Centerville) 937-438-8707or (Huber Heights) 937-235-2851.

I hereby state that I have read and fully understand the above statements as they apply to the name patient. I hereby consent to the release of medical information. **Any further disclosure of this information is prohibited unless further disclosure is expressly permitted by my written consent or by the written consent of my representative or as permitted by law.** A photocopy of this Authorization is to be accepted the same as the original.

*****Please allow 30 days for processing your record(s) request*****

___________________________ ___________________________
Patient's Name Last 4 digits of Social Security

___________________________ ___________________________
Date Signed Date of Birth

___________________________ ___________________________
Signature of Patient/Guardian Witness

Revised: 05/20/2019