First Flight Health Centers™

1323 West 3rd Street Dayton, Ohio 45402-6714

Release of Information

IMPORTANT: Charges for this request may apply. Allow 5 business days for processing. Form must be HIPAA compliant and will not be processed if invalid.

Physician/Site Authorized to **Release** Information:

Name:_____

Address:_____

_____

Phone/Fax:_____

Physician/Site/Person Authorized to **Receive** Information:

Name:_____

Address:_____

_____

Phone/Fax:_____

For the purpose of: ☐ Self/Transfer of Care (charge may apply) ☐ Continuity of Care/Treatment ☐ Insurance Claim

☐ Legal Matter (specify) _____ ☐ Other (specify) _____

Patient Name (include previous name): _____

Date of Birth:_____ Phone:_____

Address:_____ Apt #:_____

City/State/Zip:_____

Format: ☐ Electronic Copy ☐ Paper Copy

☐ Fax ☐ Pick up ☐ Mail ☐ Encrypted Email: _____

Information for release:

☐ **Medical:** **Date(s) of Service:**_____

☐ Demographic Sheet ☐ Chart Notes ☐ Laboratory Reports ☐ ER Reports

☐ Immunizations ☐ Consultations ☐ Radiology Reports ☐ Hospital Reports

☐ Billing Records ☐ Other (specify)_____

☐ **Dental:** **Date(s) of Service:**_____

☐ Treatment Records ☐ Radiology Images ☐ Billing Records

☐ **Behavioral Health:** **Date(s) of Service:**_____

Federal Regulation Code 42, part 2 prohibits unauthorized disclosure of these records

☐ Psychiatric Notes ☐ Psychotherapy Notes

☐ Psychiatric Assessment ☐ Behavioral Health Diagnostic Assessment

☐ Other (specify)_____

Signature:_____(**MUST** Sign for Behavioral Health)

I hereby grant my permission for the release or review of the above information concerning my healthcare. I understand this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and that by signing below, I am authorizing the release of this information. I understand that the information I authorize a person or entity to receive may be re-disclosed unless it is information pertaining to substance use disorder treatment which is protected through the 42 CFR part 2 and prohibits re-disclosure. I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization may be withdrawn at anytime in writing (see Notice of Privacy). This authorization will be effective for sixty (60) days after I sign and date the form below, unless I specify an earlier expiration date in the provided space:_____

_____ _____ _____

(Date) **(Patient/Guardian/Representative Signature)** (Witness)

If above signature is not the patient, please print name: _____

☐ Minor ☐ HCPOA ☐ Executor ☐ Guardianship ☐ Deceased ☐ Other (specify)_____

Office Use ONLY

Copy of ROI Given to Patient: ☐ Yes ☐ No Date Completed:_____

Note: _____