Choices In Community Living, Inc.
1651 Needmore Road
Dayton, Ohio 45414

Authorization for the Release of Health Information

I hereby authorize Choices In Community Living, Inc., to disclose my individually identifiable health information as described below.

____

Client Name | Social Security Number | Date of Birth

Name & address of person(s) or organization(s) requesting records, if different than client:

____
____
____
____

Name & address of person(s) or organization(s) requesting records, if different than client:

____
____
____
____

❑ I will review the records at the facility.

❑ I wish to have the following records copied, and I will pick them up at the agency.

❑ I am requesting that the agency copy the following records, and send the records to the above address.

Information Requested (please initial)

I am requesting the following records from the client's medical record that were created between ___/___/___ and ___/___/___:

___	Dietary Notes	___	Activity Notes	___	Nursing Notes
___	Physician Orders	___	Physician Progress Notes	___	Care Plans
___	Discharge Summary	___	X-Ray Reports	___	Lab Results

___ Other: ____

___ Other: ____

Purpose for which records will be used: ____

____

Legal Authority for Request (please initial)

___ I am the client noted above.

___ I am the client's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

___ I am the client's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the client's medical records. I understand that the client's DPAHC is effective only when the client's attending physician has determined that the client has lost the capacity to make informed health care decisions.

___ If the client is deceased: I am the executor/administrator of the client's estate, and I have attached to this authorization a valid appointment as such from a probate court.

___ The client has executed a legally binding instrument granting me the authority to obtain his/her medical records, and I have attached a copy of that instrument to this authorization.

___ The client's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the client's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, *e.g.*, a power of attorney or probate court order.

Understandings & Agreements of Requestor

1. This authorization is voluntary and I understand that the agency cannot provide services based on the signing of this authorization, unless the authorization is for (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
2. This authorization will expire ____________ from the date of my signature below.
3. I understand that I may revoke this authorizaqtion at any time by notifying the agency in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against the agency for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the agency if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the agency.
6. I understand that if I request that records be copied and sent to me that the facility will make a good faith effort to send those records to me in a reasonable amount of time.
7. I understand that if I wish to have copies of records made, then the agency will assess a fee for copying the records.
8. The facility will notify me of the total amount due for copying and shipping of the requested records; I agree that the facility will only send me the requested information once it has received payment in full for those costs.

______________________________ ______________________________

Signature of person making request | Date

____

Printed Name of person making request