The FLEXMAN nClinic
*Professional Counseling Center*

1 Elizabeth Place
West Pavilion
1st Floor, Ste. C
Dayton, OH 45417

**For Office Use Only:** Fee Collected: _____
Identification Presented: _____
Date Received: _____ By (Initials): _____

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ Telephone #: _____

Date of Birth: _____ Patient's Social Security #: _____

**Provider/Agency/Individual RELEASING Records:**
Name/Organization: _____

Phone: _____ Fax: _____

Address: _____ City/State: _____ Zip: _____

**Provider/Agency/Individual RECEIVING Records:**
Name/Organization: _____

Phone: _____ Fax: _____

Address: _____ City/State: _____ Zip: _____

Information May Be: ☐ Faxed ☐ Mailed ☐ Reviewed Only ☐ Discussed via telephone ☐ In Person Meeting
☐ Verbal Communication only (no records needed)

I authorize release ***except for the following stipulations***: _____

**Information to be released:**

_____ Copies of basic information (face sheet discharge summary, H&P)
_____ Copies of pertinent information (basic information and test results)
_____ Discharge summary/face sheet only
_____ Other (specify): _____

**Dates of Treatment:** _____

_____ Consultations
_____ Copies of Neuropsychological Evaluation(s)
_____ Progress Notes

Purpose of Information Requested: ☐ Continuity of Care ☐ Legal ☐ Insurance ☐ Personal
☐ Other (Specify) _____

I hereby authorize The Flexman Clinic to release and/or receive medical information, as indicated herein, to/from the above party. This authorization includes release of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions of the above-mentioned patient.

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying The Flexman Clinic at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken to reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal low may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

_____ _____
DATE SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____ _____
SIGNATURE OF WITNESS RELATIONSHIP TO PATIENT