Orthopaedic Institute of Dayton
3205 Woodman Drive, Dayton, Ohio 45420
Phone: (937)298-4417 Fax: (937)298-8260

Authorization for release of protected health information

Please allow 7-10 business days for your request to be processed.

PATIENT NAME: _____ DOB: _____

PHONE #'S: _____

Protected health information is being released for the purpose of:

MEDICAL RECORDS FROM OID RELEASED TO:	**MEDICAL RECORDS TO OID RELEASED FROM:**
Name _____	Name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
Phone #_____	Phone # _____
Fax # _____	Fax # _____

MEDICAL RECORDS ☐ XRAYS ☐ MRI DISC ☐

PHYSICIAN: _____ BODY PART: _____
COMMENTS: _____

DISABILITY/FMLA FORM ☐ **FAMILY/SPOUSE FMLA FORM** ☐

Company _____

Attn: _____

Address _____

Phone # _____Fax #_____

Disability Start Date _____ Return to Work Date _____

FEES: There is a $20.00 processing fee per set of disability/FMLA forms and for any updates. There is also a processing fee for copies of medical records and x-ray's. Fees are based upon records requested and the volume of your file. This fee can be paid at drop off or pick up of form or by credit card over the phone. This is payable by you to OID and payment may be made via check, money order, cash, or by credit card.

□ P/UP □ CALL TO PAY PER PHONE (MAIL OR FAX RECORDS) □ MAIL INVOICE

This authorization shall be in effect for one (1) year.
I understand I have the right to revoke this authorization at any time by sending written notification to Pam Hough at OID, Inc. I understand that information released by use of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to inspect or copy the protected health information to be released as permitted under federal law. I understand that I have the right to refuse to sign this authorization. I understand I have the right to receive a copy of the signed authorization.

X_____

PATIENT SIGNATURE **DATE**

******* OFFICE STAFF USE ONLY *******

ACCOUNT # _____ DOCTOR _____

DATE RECEIVED _____ INITIALS _____ PAID _____