United Rehabilitation Services Of Greater Dayton

4710 Old Troy Pike
Dayton, OH 45424
(937) 233-1230
Fax: 236-8930

2011 Authorization for Use and/or Disclosure of Protected Health Information

_____ Patient's Full Name (Please print)

_____ DOB

_____ Social Security Number

All audiology and therapy documentation will be disclosed, unless otherwise stated.

Dates of treatment requested: _____

All records will be mailed, however, records can be emailed, faxed, and picked up in person, upon verbal request.

(Below please list who you would like us to send records to)

Disclose Records To:

Name:_____
Organization:_____
Title: _____
Address:_____
City,State,Zip_____
Phone:_____
Email:_____

Name:_____
Organization:_____
Title:_____
Address:_____
City,State,Zip_____
Phone:_____
Email:_____

Name:_____
Organization:_____
Title: _____
Address:_____
City,State,Zip_____
Phone:_____
Email:_____

Name:_____
Organization:_____
Title:_____
Address:_____
City,State,Zip_____
Phone:_____
Email:_____

This authorization will expire 1 year after the date below, or sooner by my choice, in which case, authorization will expire on_____, or _____ (event) occurs. This authorization may be revoked at any time to the extent that use and/or disclosure have not already occurred prior to your request revocation. In order to revoke the authorization the individual/parent/legal guardian must submit a revocation request in writing. Please refer to United Rehabilitation Services (URS) Notice of Privacy Practices.

URS will not condition treatment, payment, enrollment, or eligibility on the execution of this authorization. The information used or disclosed as a result of this authorization may be subject to re-disclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

I, the undersigned, hereby authorize United Rehabilitation Services to use and/or disclose information from my (or give relationship)_____ _____ medical or financial record as specified above. This authorization includes the use and/or disclosure 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 to the above mentioned entity(s).

Signature:_____Date:_____ ☐Patient ☐Parent ☐Legal Guardian

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the authorization. If URS requests this authorization for its own use or disclosure, a copy of this authorization must be provided to the individual completing this form.