First Dayton Cancer Care
2632 Woodman Center Court Kettering, Ohio 45420
P: (937) 293-2273 F: (937) 293-6573

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Please fill out the following highlighted areas.

This grants First Dayton Cancer Care permission to request and / or release your medical records.

I hereby consent to authorize _____
Name of Physician / Practice

To release information from the medical record of:

_____
Patient Date of Birth

The information is to be released to:

☐ First Dayton Cancer Care
2632 Woodman Center Court
Kettering, Ohio 45420
Phone: (937) 293-2273
Fax: (937) 293-6573

OR

☐ Other Dr. or Facility Name
_____
_____
_____
_____

And shall include information from the above-named facility's records, including photocopies, relating to the patient's identity, diagnosis, prognosis, and/or treatment including:

____ All records pertinent to continued care
____ History & Physical ____ Radiation Summary ____ Imaging Reports
____ Pathology / OP Notes ____ Physician Notes ____ Lab Reports

The purpose of this request is for:

__X__ Continuity of care

I wish my records to be:

☐ faxed to _____ ☐ mailed to _____ ☐ held for pick up

I understand that I might be releasing to the person/organization identified above, information which is specially protected under provisions of state and/or federal law. I understand that I may revoke this authorization at any time except to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. To revoke this authorization, I must advise First Dayton Cancer Care in writing at the above address of my revocation. I further understand that, if not revoked earlier, this consent will remain in force for 90 days.

_____
Patient's Signature Date

_____
Signature of Parent/Legal Guardian/Authorized Representative Date

_____
Signature of Witness Relationship to Patient Date