Miami Valley Heart and Lung Surgeons, Inc.
30 East Apple Street, Suite 6252
Dayton, Ohio 45409
(937) 208-6060

Release of Information – (HIPPA)Authorization Form

I, ___________________________, authorize Miami Valley Heart and Lung Surgeons, LLC to use or disclose the protected health information listed below to [____].

The information that I authorize to be released include:

- ☐ Office Notes ☐ Consultation Notes ☐ Office Test Results
- ☐ Surgical Reports ☐ Discharge Summaries ☐ History & Physical
- ☐ Statement/Billing Reports ☐ Office Correspondence, Incoming/Outgoing
- ☐ Test Results Received from other parties (hospital, referral sources, etc.)
- ☐ Medical Reports to outside entities (insurance companies, home care companies, etc.)
- ☐ Other: ____

The purpose for this request is: ☐ At patient request or (describe reason for release)
☐ ____

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This authorization is valid until _____________________________ at which time this authorization expires. If I fail to indicate an expiration date or event, this authorization will expire six months from the date this authorization is executed.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to Miami Valley Heart and Lung Surgeons, LLC.

I understand that if I revoke the authorization, the revocation will not apply to information that has already been released in response to the authorization.

I also understand that the revocation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.

I understand that authorizing this use or disclosure is voluntary. I understand that I have the right to refuse to sign this authorization. Refusing to sign will not affect my ability to be treated by Miami Valley Heart and Lung Surgeons, LLC.

If I have questions about the use and disclosure of my information, I can contact the Practice Administrator at 937-208-6060.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

c: copy to patient