PLASTIC SURGERY INSTITUTE OF DAYTON, INC.
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize **PLASTIC SURGERY INSTITUTE OF DAYTON, INC**. (Practice) to use and/or disclose certain protected health information (PHI) about me to_________________________________. This authorization permits the Practice to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.): ____________________________________

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The information will be used or disclosed for the following purpose: _______________________

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If requested by the patient, the purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ____________________________________.

The Practice ____ will ____ will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization.

I understand that my medical records will be sent either secure email, faxed or USPS delivery within 30 days of this signed PHI release form. _______*Initials*

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy Officer at Plastic Surgery Institute of Dayton, Inc., located at 9985 Dayton Lebanon Pike, Centerville, OH 45458.

____________________________________	______________________
Signature of Patient or Legal Guardian	Date of Signature
____________________________________	______________________
Printed Name of Patient or Legal Guardian	Relationship to Patient

Patient/Legal Guardian to be provided with a signed copy of authorization.

Revised 2/19/2022