Authorization to Release Protected Health Information

Dermpath Laboratory of Central States (DLCS) - 7835 Paragon Road, Dayton, OH 45459. Phone: 800-532-3232 Fax: 937-436-4157

Full Name *(Last, First, Middle)*	**Birth Date** *(Month DD, YYYY)*	**Last 4 digits of SSN**

Referring Physician's Office

Name _____

Address _____

City_____ State_____ ZIP Code_____ Phone_____ Fax _____

Release Information From

☐ Dermpath Laboratory of Central States (DLCS)
7835 Paragon Road, Dayton, OH 45459

☐ Dermpath Laboratory of Central States (DLCS)
1100 Owendale Drive, Suite A, Troy, Michigan 48083

Mail report(s) to

☐ Self ☐ Legal Guardian
☐ Other (Specify facility/individual and address below, including phone/fax if known.)

Name:_____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone: _____ **Email:** _____

Purpose of Release

☐ Treatment/Continued Care ☐ Personal ☐ Legal Purposes ☐ Other

_____

Pathology Report(s)

Service Dates *(Month DD, YYYY)* **List all.**

I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ☐ Parent ☐ Legal Guardian

Signature (Required)			**Date Signed** (Required) *(Month DD, YYYY)*
Printed Name of Person Signing (If Not Patient)			
Mailing Address of Patient - Street			
City	State	ZIP code	Phone
Phone	Fax	Email	