



Mid Ohio DDA

MODDA HIPAA Policy upon request

PART 1: CONSENT FOR RELEASE OF INFORMATION

I _____, hereby authorize MODDA physicians and/or staff to disclose my health information to the following people who are involved in my care.

If **no** then please skip to Part 2 at bottom of this page.

_____ (*check only if yes*) Authorization to release information to person(s) mentioned below:

Person's Name:

Relationship to Patient:

PART 2: MESSAGE AUTHORIZATION

_____ (*check only if yes*) Authorization to leave messages on an answering machine/voice mail if there is no answer at the number provided with a detailed test or procedure results.

I understand that I may revoke this consent at any time by notifying MODDA in writing.

X _____
(Signature of patient or POA)

(Date)