D.D.T.A. SERVICES, INC.

P.O. BOX 461, East Palestine, OH 44413 (330)426-1941 or (800) 488-3382

AUTHORIZATION FOR RELEASE OF INFORMATION

(Please Print)

I hereby authorize D.D.T.A. Services, Inc, its MRO, and staff to release the following information from the health record(s) of:

______________________________ (Patient Name) ______________ (SSN)

______________________________ (Patient Address) ______________ (Date of Birth)

INFORMATION TO BE RELEASED:

[ ] Copy of complete health record
[ ] History and physical
[X] Drug Screen result
[ ] X-rays
[X] Lab reports
[X] Breath Alcohol result
[ ] Other - please specify:
…covering the period(s) of service from: __________ (Date) to __________ (Date)

INFORMATION IS TO BE RELEASED TO:
AIM Nationalese / AIM Dedicated Logistics
1500 Trumbull Avenue, Girard, OH 44420

Purpose of Disclosure: Company Policy

Expiration Date of Authorization:
This autorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient's personal representative.
Right to Terminate or Revoke Authorization:
You may revoke or terminate this authorization by submitting a written revocation to us at the above address, *Attention: Compliance Officer*. Please understand that disclosures made in good faith may have already occurred in reliance on this authorization.
Potential for Re-disclosure:
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. This facility, its employees and officers, and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Information concerning substance abuse or HIV testing will not be requested or released without specific wirtten authorization for the release of such information.

SIGNATURE/PATIENT REPRESENTATIVE: ______________________
PRINT NAME: ______________________ **DATE:** __________
RELATIONSHIP TO PATIENT: Employer
WITNESS: ______________________ **DATE:** __________