Authorization for Disclosure of Health Information

Part 1 Authorization (Patient Information)

I authorize Columbus Regional Health Physicians Neurology & Sleep Sciences Fax 812/376-4718
to disclose the following information from medical records of:

Patient Name:_____ **Date of Birth:**_____
Address:_____ **Telephone:**_____

Maiden or other name at time of service:_____
Date of Health Care Service: From: (date) _____ To: (date) _____

Part 2 Information to be Disclosed

- ☐ Office Notes
- ☐ Laboratory Report
- ☐ Pathology Report
- ☐ Record of HIV and Communicable Disease Testing
- ☐ All Medical Record
- ☐ Accounting of Disclosures
- ☐ Radiology Report
- ☐ Other_____

I understand that this authorization will include information relating to (check if applicable):

☐ AIDS, HIV Report ☐ Treatment for alcohol and / or drug abuse

Part 3 I authorized Neurology & Sleep Sciences Fax 812/376-4718 to disclose / obtain protect health information about me to / from
(Practice Name)
the individuals list below: ☐ Release Information to ☐ Obtain Information From

Name of Individual / Entity Name	Phone	Fax
Address	City	Zip

For the purpose of:_____

Part 4 Columbus Regional Health Physician, its workforce, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Part 5 I understand that this Authorization will expire 60 days after the date signed and is subject to written revocation at any time prior to the expiration date except to the extent that action has been taken in reliance thereof.

_____ _____
Signature of Patient or Legal Representative **Date**
(Indicate relationship if other than patient: ☐ Parent / Guardian ☐ Patient's Personal Representative)

_____ _____ ID Verified ☐ Yes ☐ No
Signature of Witness **Date**

Part 6 Revocation:

I wish to revoke this authorization: (sign and date):_____ _____

Person witnessing revocation: (sign and date):_____ _____

Any disclosure of Medical Record Information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.
This authorization complies with 45 CFR 164.508 and IC 16-39-1-4

- I understand I may be charged for the records and I have been notified of charges as stated below:
  - ¤ A flat fee of $6.50 per patient request plus:
    - $0.01 - 0.02 per page for records that are stored in paper and scanned
    - $0.05 per page for records that are printed and delivered in hard copy
    - Actual postage for records that are delivered in hard copy
  - ¤ A copy service may be used to copy and send records. If so, you will receive a bill directly from them.

COLUMBUS REGIONAL HEALTH PHYSICIANS LLC
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