COLUMBUS PEDIATRICS
COLUMBUS REGIONAL HEALTH

Patient Authorization for Practice to Release
Protected Health Information to Third Parties

By signing this authorization, I authorize Columbus Pediatrics to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

Authorized to release from (Previous Provider): Authorized to receive (Who is to Receive):

_____ _____
Releasing Information-Previous Provider To receive Information

_____ _____
Address of Previous Doctors Office Address

_____ _____
City / State / Zip City / State / Zip

This authorization permits Columbus Pediatrics to use or disclose copies of the following individually identifiable health information:

_____ Contents of entire medical record including information on drug, alcohol, mental health and infectious disease.
_____ Contents but exclude information on drug, alcohol, mental health and infectious disease
_____ Contents but exclude information from any other doctors, facilities, etc.
_____ Other (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). :_____

for the purpose of:_____

I understand this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. This consent will expire in 60 days.

Indiana Code #16-39-1-1 provides a written request may be made and provided to you in a specified manner for an appropriate fee, therefore, I understand and agree that I may be financially responsible for fees associated with my request.

I understand this facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent and authorized herein.

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 Columbus Pediatrics has acted in reliance upon this authorization. My written revocation must be submitted to Columbus Pediatrics Privacy Officer at 1120 N. Marr Road, Columbus, Indiana, 47201.

Patient Information & Authorized Signatures:

_____ _____
Patient Name Date Of Birth Relationship to Patient

_____ _____
Signature of Patient / Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

( ) Mail ( ) Pick Up ( ) Fax

Action Taken: _____ Date: _____ Staff Name: _____