



COLUMBUS ENT & ALLERGY
COLUMBUS REGIONAL HEALTH

Authorization for Disclosure of Health Information

PART 1 AUTHORIZATION (Patient Information)

I authorize Columbus ENT & Allergy, 2326 18th St, Ste 230, Columbus, IN 47201 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, Radiology Report, Record of HIV and Communicable Disease Testing, Other, All Medical Record, Accounting of Disclosure

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 authorize: to disclose/obtain protect health information about me to/from the individual listed below. (Practice Name)

To Release Information To To Obtain Information From

Name of Individual/Entity Name: Phone: Fax:

Address City Zip

For the purpose of:

PART 4 Columbus Regional Health Physicians, 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
o A Flat fee of \$6.50 per patient request plus
o \$.01-.02 per page for records that are stored in paper and scanned
o \$.05 per page for records that are printed and delivered in hard copy
o Actual postage for records that are delivered in hard copy
o A copy service may be used to copy and send records. If so, you will receive a bill directly from them