

Authorization for Disclosure of Health Information

PART 1 AUTHORIZATION (Patient Information)

I authorize Columbus Regional Hospital or (other facility) _____
to disclose the following information from medical records of:

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

Address: _____ **Telephone:** _____

Medical Record No.: _____

Social Security No.: _____ - _____ - _____

Maiden or other name at time of service: _____

Date of Health Care Service:

From: (date) _____ To: (date) _____

PART 2 INFORMATION TO BE DISCLOSED

- | | | |
|--|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History & Physical Examination | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Laboratory Report | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Radiology CD |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Therapy Records (PT, OT, ST) |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Emergency Room Report | |
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Accounting of Disclosures |

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

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS, HIV Report | <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> Treatment for alcohol and/or drug abuse |
|---|--|--|

PART 3 This information is to be disclosed/given to:

For the purpose of: _____

PART 4 Columbus Regional Hospital, 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)

_____/_____/_____
Signature of Witness **Date**

ID Verified Yes No

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



COLUMBUS REGIONAL HOSPITAL
2400 EAST 17TH STREET, COLUMBUS, INDIANA 47201
800-841-4938 812-379-4441

**Authorization for Disclosure
of Health Information**

PATIENT LABEL
OR

Patient Name: _____

DOB: _____/_____/_____

MR #: _____