COLUMBUS INTERNAL MEDICINE ASSOCIATES

COLUMBUS REGIONAL HEALTH

Fax #: 812-378-7761 Phone: 812-376-9427

# Authorization for Disclosure of Health Information

**PART 1 AUTHORIZATION** (Patient Information)

I authorize Columbus Internal Medicine Associates, 4050 Central Ave, Columbus, IN 47203
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 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
    - $.01-.02 per page for records that are stored in paper and scanned
    - $.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