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.:** ____________________

Maiden or other name at time of service: ____________________

Date of Health Care Service:

From: (date) ____________________ To: (date) ____________________

PART 2 **INFORMATION TO BE DISCLOSED**

☐ Discharge Summary ☐ History & Physical Examination ☐ Operative Report
☐ Laboratory Report ☐ Radiology Report ☐ Radiology CD
☐ Pathology Report ☐ Consultation Report ☐ Therapy Records (PT, OT, ST)
☐ Progress Notes ☐ Emergency Room Report ☐ Accounting of Disclosures
☐ All Medical Records ☐ Other ____________________

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

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

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)

____________________ ____________________ 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

MR-19 (03/08/19)

COLUMBUS REGIONAL HOSPITAL

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Authorization for Disclosure of Health Information

PATIENT LABEL

OR

Patient Name: ____________________

DOB: ______/______/______

MR #: ____________________