

**Authorization for Use/Release of Health Information**

(This form applies only to the release and disclosure of information. It is not a consent for treatment or intended for any other purposes.)

**By signing this form, I authorize The Columbus Clinic to use, release or disclose the protected health information described below to:**

Name of Person and/or Organization to Whom Information Should be Sent:

\_\_\_\_\_

Address of Person/organization to Whom Information Should be Sent: \_\_\_\_\_

\_\_\_\_\_

Please send this information on or about (information will not be resent without another authorization):

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

This authorization expires upon fulfillment of request unless special circumstances noted below\*\* Mo  
Day  
Year

Purpose of disclosure (at request of patient, employment, life or disability insurance, etc.):

\_\_\_\_\_

**I authorize the following information to be sent to the address above:**

\_\_\_\_ Copies of all medical records for the period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ Copies of the information described below for the period \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_ History & Physical Exam \_\_\_\_ Lab, X-Ray, etc. Reports \_\_\_\_ Reports from Other Physicians

\_\_\_\_ Other (Please Specify) \_\_\_\_\_

\_\_\_\_ \*HIV Records \_\_\_\_ \*Alcohol and/or Drug Records \_\_\_\_ \*Psychotherapy Records

\* Must have physician approval and signature before releasing information

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The following information should **not** be released, even if occurring during dates listed above-

I understand that there may be information in these records that I would not want released.

I have been provided a copy of The Columbus Clinic's *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with The Columbus Clinic's Privacy officer or other appropriate office personnel.

I understand that The Columbus Clinic assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release The Columbus Clinic from all legal liability that may arise from this authorization.

**Patient name:** \_\_\_\_\_ **Patient Signature: X** \_\_\_\_\_  
(Please print)

**Date:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

If the signature above is not that of the patient, I am acting for the patient because \_\_\_\_\_

\_\_\_\_\_

My relationship to the patient is: \_\_\_\_\_ Signed: \_\_\_\_\_

The patient or their representative may revoke this authorization by notifying in writing The Columbus Clinic's designated Privacy officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.