Authorization for Disclosure of Protected Health Information

Columbus Psychiatry

Patient Name: ______________________________ Date of Birth ______________

Full Address: ______________________________

Phone Number: ______________________________

Maiden/Previous Names: ______________________________

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility:

____

Address:

____

City/State/Zip

____

Phone:

____

Release Information To:

Name/Facility:

____

Address:

____

City/State/Zip

____

Phone:

____

Purpose of Release:

❑ Continuing Medical Care
❑ Insurance Claim
❑ Application for Insurance
❑ Work Comp
❑ Disability Determination
❑ Personal
❑ Other: ______________________________

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Delivery Method: Date information desired by: ______________________________

Release Format (Check 1 of 3 options only):

❑ Paper via ❑ Mail **OR** ❑ Pick Up **OR** ❑ Fax (*as appropriate*) **Fax # :** ______________________________

Per Ohio Revised Code 3701.741, you may be charged a fee for copies of medical records. If you have any questions about copying fees please contact Columbus Psychiatry at 614-664-7792

Information to be Released:

Service Dates: From: ______________ To: ______________ **OR** ❑ all future records until this authorization expires

NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: ______________________________

❑ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

❑ Discharge Summary
❑ Psychological Evals/Assmts
❑ Lab / Pathology Reports
❑ Billing Statements
❑ ER Records
❑ EKG / Cardiology Reports
❑ Radiology Images
❑ Other: ______________________________
❑ History & Physical
❑ Immunization Records
❑ Radiology Reports
❑ Clinic Visit Notes
❑ Operative Reports
❑ Entire Medical Record *(charge may apply)*
❑ Alcohol/Drug Treatment Records ______________________________

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

______Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature *(required)*:	**Date Signed** *(required)*:
Printed Name of Person Signing (If not patient):	