COLUMBIA MEMORIAL HOSPITAL
AUTHORIZATION FORM FOR THE RELEASE OF PATIENT INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to redisclosure and may no longer be protected by the federal privacy regulations.

Patient name: _____
Date of Birth: ____/____/____

___ I would like a copy of these records.

Persons/Organizations authorized to receive my information: _____
Recipient's Address/Phone and/or Fax Number: _____
_____

Specific description of the information to be used or disclosed (including date(s)):
_____

Description of each purpose of the use or disclosure of my patient information: **(*Note:* If the release of information is requested by the patient, please insert "at the request of the patient" here if the patient does not provide a statement of purpose.)**
_____

For marketing authorizations only:
_____
_____
_____

Section B: The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire one year from date of signatures unless otherwise specified.

Initials: _____

2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.

Initials: _____

3. I understand that I will get a copy of this form after I sign it if I request it.

Initials: _____

4. I understand that I may revoke this authorization at any time by notifying the Hospital in writing, but if I do, the revocation will not have any effect on actions the Hospital has already taken in reliance on this authorization.

Initials: _____

5. I understand that any information pertaining to HIV-related treatments, Alcohol or Substance Abuse, Genetic Information (i.e. Sickle-Cell Anemia) and Psychotherapy records may enjoy greater confidentiality protection. I hereby recognize that this information is in the records that I have requested on this authorization.

Initials:_____

_____ _____

Signature of patient or patient's representative Date

(Note: This form MUST be completed before signing.)
If this authorization is signed by a patient's representative, please complete the following:

_____

Printed name of patient's representative

_____

Relationship to patient

Describe the representative's authority to act for the patient:

_____

_____

Witnessed by _____ on (date) _____.