ColumbiaDoctors

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED PARTY

Patient Name: _____

Physician Name: _____

Department/Practice: _____

Designated party: _____

Relationship to Patient: _____

Address: _____

Phone: _____

Designated Party: _____

Relationship to Patient: _____

Address: _____

Phone: _____

The information will be used or disclosed for the following purposes:

___At the request of the individual ___Other_____

This Authorization grants permission to the Designated Party(ies) named above to:

____have access to my medical record information

____have access to my billing & insurance information

____have access to any test results

____make or confirm appointments

____other, please specify_____

I authorize ColumbiaDoctors to use and disclose my health information as described in this authorization.
The patient or the patient's representative must read and initial the following statements:

- I understand that this information will: (Must check one)
  ___expire 1 year from the date signed by the patient or patient's representative; or
  ___only when revoked by the patient
- I understand that I may revoke this authorization at any time by notifying in writing the above named Physician
  Practice at ColumbiaDoctors; however, if I do revoke the authorization, it will not have any effect on any actions taken by ColumbiaDoctors prior to their receipt of the revocation
- I understand that this authorization is voluntary
- I understand that once this information is released to the Designated Party (ies), the released information may no longer be protected by federal privacy regulations
- I understand that my treatment cannot be conditioned on whether I sign this authorization

_____ _____

Signature of patient or patient's representative Date
(Form MUST be completed before signing or will not be valid)