CMH
Columbia Memorial Health

AUTHORIZATION FORM FOR THE RELEASE OF PATIENT INFORMATION

* A U T H – R E L – I N F O *

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 re-disclosure and may no longer be protected by the federal privacy regulations.

Patient Name: _____

Date of Birth: _____ /_____ /_____

Columbia Memorial Hospital is authorized to **release** my information: _____

Persons/Organizations authorized to **receive** my information, please include the 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 provided a statement of purpose.)**

_____

For marketing authorizations only:_____

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AUTH-REL-INFO

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

1. I understand that this authorization will expire one year from the date of signature, 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. I hereby recognize that this information may be in the records that I have requested on this Authorization.**

   Initials: _____

_____ _____

Signature of patient Date

(Note: This authorization MUST be completed before signing.)

If this authorization is signed by a patient's representative please complete the following:

_____

Printed name and relation of patient's representative