CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

TO FAMILY AND FRIENDS

I authorize the Columbus Oncology Associates, Inc ("**COA**") to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my health care provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed authorization. This permission will be considered ongoing until I indicate otherwise in writing.

My Protected Health Information may be released to the following individuals:

1._____

2. _____

3. _____

4. _____

COA STAFF HAVE MY PERMISSION TO LEAVE MESSAGES CONCERNING TREATMENT (i.e., LAB RESULTS) on my: (Please check all boxes that apply)

- ☐ Home Voice Mail. Home Phone number: _____
- ☐ Cell phone. Cell phone number: _____
- ☐ Work Voice Mail. Work phone number: _____
- ☐ **NO INFORMATION:** I do not authorize the release of any verbal information (other than appointment reminders to the number(s) that I have provided).

_____ _____

Print Name of Patient *Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date Signed

Authorized Representative's authority* to act on the Patient's behalf:

☐ Parent/legal guardian ☐ Power of Attorney

*Evidence of authority must be provided and on file with COA.