



Authorization to Disclose (Release) Protected Health Information (PHI)

Patient Information

Last Name		First Name		Middle	Date of Birth
Address				City	State Zip
Phone Number		Email Address		Date(s) of Service	
Purpose of Release:	<input type="checkbox"/> CONTINUITY OF CARE / MEDICAL TREATMENT		<input type="checkbox"/> LEAVING PRACTICE / CHANGE OF DOCTOR		
	<input type="checkbox"/> SELF / PERSONAL REASONS		<input type="checkbox"/> EMPLOYMENT RELATED		
	<input type="checkbox"/> DISABILITY		<input type="checkbox"/> LEGAL REASONS		
	<input type="checkbox"/> INSURANCE		<input type="checkbox"/> OTHER (please specify) _____		

Provider/Organization Authorized to RELEASE information		Provider/Organization Authorized to RECEIVE information	
Name:		Name:	
Address:		Address:	
City, State, Zip		City, State, Zip	
Fax #:	Phone #:	Fax #:	Phone #:

Method of Release: Fax to Provider/Organization Mail to Provider/Organization Mail to patient Picked up by _____

Information to be Released: – For the record(s) selected above, specify the information to be released below.

<input type="checkbox"/> COMPLETE RECORD <u>OR</u>	<input type="checkbox"/> PROGRESS NOTES – Most recent	<input type="checkbox"/> HOSPITAL RECORDS
<input type="checkbox"/> PROGRESS NOTES – ALL	<input type="checkbox"/> CONSULTATIONS	<input type="checkbox"/> DISCHARGE SUMMARIES
<input type="checkbox"/> LAB REPORTS	<input type="checkbox"/> PATHOLOGY	<input type="checkbox"/> MEDICATION LISTS
<input type="checkbox"/> RADIOLOGY/SCANS	<input type="checkbox"/> OTHER – PLEASE SPECIFY _____	
<input type="checkbox"/> OTHER DIAGNOSTIC TESTS		

Authorization Expiration, Redis closure, and Revocation

- This authorization for release of information will expire one year from the date signed below
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. However, other state or federal regulations may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information
- I understand that I may revoke this authorization, in writing, at any time except to the extent to which Columbus Oncology Associates, Inc. has relied on this information to release protected health information. Revocation must be made in writing and submitted to Columbus Oncology Associates, Inc. 810 Jasonway Ave., Columbus, Ohio 43214
- I understand that treatment or payment of my claims will not be impacted by signing this form
- I understand that my medical records cannot be released until I sign this form

According to Ohio Revised Code, there is a per page fee for medical records. This fee will depend on the number of copies requested and other reasons as specified in OC 3701.741 at codes.ohio.gov/ORC

I hereby authorize Columbus Oncology Associates, Inc. to disclose to the party named in this document, information from my medical record for the reasons and dates specified. I understand and acknowledge that this may include information related to testing, diagnosis, or treatment of sickle cell disease, physical or mental illness, HIV/AIDS, and or alcohol/drug abuse.

Signature of Patient

Date

Signature of Patient's Legal Representative

Date

Relationship to Patient

If signed by Patient's Legal Representative, please provide a copy of the document authorizing your authority on the patient's behalf (e.g. healthcare power of attorney)