Columbus Oncology & Hematology
Serving Ohio Since 1987

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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) **Name:**_____________________________ **Relationship:**_____________________ **Phone:**______________

2) **Name:**_____________________________ **Relationship:**_____________________ **Phone:**______________

3) **Name:**_____________________________ **Relationship:**_____________________ **Phone:**______________

4) **Name:**_____________________________ **Relationship:**_____________________ **Phone:**______________

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/Authorized Representative

____
Patient Date of Birth

____
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.

Revised Feb 2020