Columbus Oncology & Hematology
Serving Ohio Since 1987

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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:

- ☐ CONTINUITY OF CARE / MEDICAL TREATMENT
- ☐ SELF / PERSONAL REASONS
- ☐ DISABILITY
- ☐ INSURANCE
- ☐ LEAVING PRACTICE / CHANGE OF DOCTOR
- ☐ EMPLOYMENT RELATED
- ☐ LEGAL REASONS
- ☐ 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.

☐ COMPLETE RECORD **OR**

- ☐ PROGRESS NOTES – Most recent
- ☐ PROGRESS NOTES – ALL
- ☐ CONSULTATIONS
- ☐ LAB REPORTS
- ☐ PATHOLOGY
- ☐ RADIOLOGY/SCANS
- ☐ OTHER DIAGNOSTIC TESTS
- ☐ HOSPITAL RECORDS
- ☐ DISCHARGE SUMMARIES
- ☐ MEDICATION LISTS
- ☐ OTHER – PLEASE SPECIFY

_____

_____

Authorization Expiration, Redisclosure, 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)