COLUMBIA MEMORIAL HOSPITAL

AUTHORIZATION FORM FOR THE RELEASE OF PATIENT INFORMATION

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 redisclosure and may no longer be protected by the federal privacy regulations.

Patient name: ____

Date of Birth: ____/____/____

___ I would like a copy of these records.*

Persons/Organizations authorized to receive my information: ____________

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 provide a statement of purpose.)**

____

For marketing authorizations only: _______________________________

**There will be a copying fee for these records. The fee will be $0.75 per page. In addition, the Hospital will charge you for the cost of mailing the copies to you, if requested. The hospital by law has 10 business days to fulfill your request.*

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

1. I understand that this authorization will expire one year from date of signatures 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 protection. I hereby recognize that this information is in the records that I have requested on this authorization.**

   Initials:___________

___________________________________ ______________

Signature of patient or patient's representative Date

(<u>Note:</u> This form MUST be completed before signing.)

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

____

Printed name of patient's representative

____

Relationship to patient

Describe the representative's authority to act for the patient:

____

____

Witnessed by ____________________________ on (date) _________________.