



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED PARTY

Patient Name: _____

Physician Name: _____

Department/Practice: _____

Designated party: _____

Designated Party: _____

Relationship to Patient: _____

Relationship to Patient: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

The information will be used or disclosed for the following purposes:

At the request of the individual Other _____

This Authorization grants permission to the Designated Party (ies) named above to:

have access to my medical record information

have access to my billing & insurance information

have access to any test results

make or confirm appointments

other, please specify _____

I authorize ColumbiaDoctors to use and disclose my health information as described in this authorization.

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

- I understand that this information will: (Must check one)
 - expire 1 year from the date signed by the patient or patient's representative; or
 - only when revoked by the patient
- I understand that I may revoke this authorization at any time by notifying in writing the above named Physician Practice at ColumbiaDoctors; however, if I do revoke the authorization, it will not have any effect on any actions taken by ColumbiaDoctors prior to their receipt of the revocation
- I understand that this authorization is voluntary
- I understand that once this information is released to the Designated Party (ies), the released information may no longer be protected by federal privacy regulations
- I understand that my treatment cannot be conditioned on whether I sign this authorization

Signature of patient or patient's representative
(Form MUST be completed before signing or will not be valid)

Date