COLUMBUS REGIONAL HOSPITAL
Authorization for Disclosure of Health Information

PART 1 AUTHORIZATION (Patient Information)

I authorize Columbus Regional Hospital or (other facility) _____

to disclose the following information from medical records of:

Patient Name:_____ **Date of Birth:**_____

Address:_____ **Telephone:**_____

_____ **Medical Record No.:**_____

PART 2 INFORMATION TO BE DISCLOSED

The information I authorize to disclose is from (date) _____ **to (date)** _____

- ☐ Discharge Summary
- ☐ History & Physical Examination
- ☐ Operative Report
- ☐ Laboratory Report
- ☐ Radiology Report
- ☐ Radiology CD
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Progress Notes
- ☐ Therapy Records (PT, OT, ST)
- ☐ Emergency Room Report
- ☐ Accounting of Disclosures
- ☐ All Medical Records
- ☐ Other_____

I understand that this authorization will include information relating to (check if applicable):

☐ AIDS ☐ HIV Report Treatment for alcohol ☐ Drug use ☐ Mental Health Record

PART 3 This information is to be disclosed / given to:

Name of person or Facility:_____ **Fax Number:**_____

Address:_____

For the Purpose of: ☐ Personal Use ☐ Continuing Care ☐ Insurance ☐ Legal use ☐ Other:_____

Requested format: ☐ MyChart ☐ Paper ☐ CD ☐ E-Mail ☐ Fax ☐ Electronic Delivery

PART 4 Columbus Regional Hospital, its workforce, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

PART 5 I understand that this Authorization will expire 180 days after the date signed and is subject to written revocation at any time prior to the expiration date except to the extent that action has been taken in reliance thereof.

_____ _____

Signature of Patient or Legal Representative — Date and Time

Copy of legal document must be provided

☐ Parent ☐ Power of Attorney ☐ Legal Guardian ☐ Executor / Administrator / Personal Representative of Estate

The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) unless the records relate to treatment(s) for which the minor may provide consent under state law.

If the patient is deceased and there is no documentation of Personal Representative of the Estate:

- ☐ I attest there is no Executor / Administrator / Personal Representative of the Estate and I am the decedent's spouse.
- ☐ I attest there is no Executor / Administrator / Personal Representative of the Estate or a spouse and I am the decedent's child.
- ☐ Other, please explain:_____
- ☐ I acknowledge that the records I am receiving are incomplete. Please initial:_____

☐ Yes ☐ No ID Verified

_____ _____

Signature of Witness — Date and Time

PART 6

I wish to revoke this authorization (sign and date):_____

Columbus Regional Hospital
2400 East 17th Street, Columbus, IN 47201
800.841.4938 812.379.4441
crh.org

Authorization for Disclosure of Health Information

PATIENT LABEL
OR
Patient Name:_____
DOB:_____/_____/_____
MR #:_____

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