COLUMBUS MEDICAL CLINIC

2122 Hwy 71 South, Columbus, Texas 78934
Phone Number: 979-732-2318 Fax Number: 979-732-2310

Authorization for: **□ Release** **□ Inspection** **□ Amendment**
Of Protected Health Information

Patient Name	Date of Birth
Address	Telephone # ( )

I hereby authorize: **COLUMBUS MEDICAL CLINIC**

To release information from the medical records of _____
Patient Name

To: _____
Name/Address of person/organization to which disclosure is to be made

Fax # _____ Phone # _____

For treatment dates _____
Specify dates – this line **MUST BE** *completed*

☐ I prefer my records be sent in an electronic format via CD.

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Other (detail below)

_____

Select Portions*

□ Abstract/Pertinent Information
□ Imaging/Radiology
□ Entire Record
□ Operative/Procedure Report
□ Lab
□ Orders
□ Consultation
□ Other_____
□ Progress Notes
□ History and Physical
□ Face Sheet
□ Emergency Department
□ Cardiac Studies
□ Nursing Notes

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, psychiatric diagnosis or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

This authorization expires 180 days from the date signed below and covers only treatment dates specified above.

I, the undersigned, have read the above and authorize the staff of the above mentioned facility to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from the release of this information and I, the undersigned, waive, on behalf of myself, my heirs, assigns and any person who may have an interest in the matter, all provisions of law relating to the disclosure of this Protected Health information.

_____ _____
Date *Signature of Patient/Parent/Guardian/DPA Healthcare*

_____
Witness

I have the legal capacity to authorize this release as I am the:
□ Patient
□ Biological Parent with Custody
□ Legal Guardian (Requires Legal Document)
□ DPA for Healthcare (Requires Legal Documentation)

Revised 6-2012; 2/2014