COLUMBIA HEALTH

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

*See p. 3 for additional information regarding your request*

## 1. Regarding Patient (Complete in full. See instructions on p. 4)

| | | |
|---|---|---|
| Name - Last, First, MI | | |
| Street Address | | Telephone # |
| City | State | Zip Code |
| UNI | Birthdate | |

## 2. Information Released From

| | | |
|---|---|---|
| Name - (i.e., Health Facility, Physician...) | | |
| Street Address | | |
| City | State | Zip Code |
| Phone # | Fax # | |

## 3. Information Released To

| | | |
|---|---|---|
| Name - (i.e., Insurance Co., Lawyer, Physician, Self...) | | |
| Street Address | | |
| City | State | Zip Code |
| Phone # | Fax # | |

## 4. Information to be Released

Date Range: _____ to _____

☐ Complete Copy of Medical Records
☐ Office Visits
☐ Immunization Records
☐ Lab Results
☐ Medication List
☐ Radiology Reports
☐ CUEMS records
☐ Specific information pertaining to: _____
_____

**Federal and state laws require special permission to release certain information. Checking "Complete Copy of Records" above only will not approve release of these special categories of information. Initial applicable sections below to authorize release**:

__ Mental Health Testing/ Treatment
__ Genetic Testing Information
__ Alcohol/Drug Treatment/Testing
__ HIV/AIDS Related Information

## 5. Purpose or Need for Disclosure

☐ Further Health Care
☐ Academics
☐ School Disability
☐ Insurance
☐ Legal
☐ Worker's Compensation
☐ Occupational Health
☐ Personal/Self
☐ Other (specify): _____

## 6. Additional Types of Disclosure

☐ By checking this box, I authorize verbal communication (i.e., telephone calls) between the parties listed in Section 2 and Section 3.
☐ By checking this box, I permit the parties listed in Section 2 and Section 3 to share my confidential health information with each other.

## 7. Expiration Date

This authorization will remain in effect for one (1) year from the date of signature unless you specify otherwise.

☐ Other expiration date: _____

****PLEASE SEE NEXT PAGE FOR FURTHER INFORMATION****

By signing below, I authorize release of my health records in accordance with the specifications listed above and on the next page of this form. I understand there may be a charge for copies. A copy of this consent shall be valid as the original.

## 8. Signature

Signature of Patient/Representative: _____ Date: _____
(If signed by person other than patient, state your relationship to the patient and your legal authority below.)

Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Legal Authority: ☐ Legal Guardian ☐ Spouse of Deceased
☐ Health Care Agent ☐ Personal Representative
☐ Other: _____

## ADDITIONAL INFORMATION REGARDING DISCLOSURE OF HEALTH INFORMATION

Columbia Health honors a patient's right to confidentiality of health information as provided under federal and state law. Please read the following regarding guidelines and your rights before signing this authorization.

**No Obligation to Sign:**
Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign, Columbia Health will not release your records.

**Revocation:**
You may revoke this authorization at any time by providing written notice to Columbia Health, except to the extent that action has already been taken based on this authorization.

**Re-release:**
Information disclosed under this authorization might be redisclosed by the recipient (except as noted in "Sensitive Information" below), and redisclosure may no longer be protected by federal or state law.

**Right to Inspect:**
You may inspect and/or receive a copy of the information described on this Authorization by completing and signing this form.

**Sensitive Information:**
By specifically authorizing the release of sensitive information (i.e., HIV/AIDS related alcohol or drug treatment, mental health treatment information, and genetic testing information), the recipient is prohibited from redisclosing such information without your authorization unless permitted to do so under federal or state law. If you experience discrimination because of the release or disclosure of sensitive information, you may contact the New York State Division of Human Rights 1-888-392-3644 or the New York City Commission of Human Rights at (718) 722-3131. These agencies are responsible for protecting your rights.

**Copying Fees:**
If you are requesting disclosure of health information to other hospitals, clinics, or physicians for further medical care, or to yourself, no copying fees will be charged. Columbia Health permitted to charge reasonable fees to recover costs for inspections and/or copying to legal agencies and insurance companies.

**Note To Recipient of Information:**
This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making further disclosures of this information without the specific consent of the patient or legal representative involved.

## INSTRUCTIONS FOR COMPLETING AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Section 1: Regarding Patient**
Please list your current address.

**Section 2: Information Released From**
Indicate the name of the organization to which information will be released from (select one per authorization) or write in the facility name and full address, phone, and fax number.

If you want information to be released from Columbia Health, please use the facility and full address, phone, and fax number listed below:

Columbia Health
Wallach Hall, Suite 125, Mail Code 4202
1116 Amsterdam Avenue
New York, NY 10027
Phone: 212-854-2284
Fax: 212-851-9357

**Section 3: Information Released To**
Indicate the specific person(s) and/or organization(s) who will be permitted to receive the information with the full mailing address, phone, and fax number.

**Section 4: Information to be Released**
Please select the applicable checkboxes identifying the information you would like to have released.

- Date Range – You are not required to, but you may enter a date range to further limit the information you want released. Please note that you must still select the applicable checkboxes of specific information you would like released.
- Complete Copy of Records – Selecting this option will authorize the release of your entire medical record. We recommend this selection for individuals who wish to have a copy of their health information for their personal health record.
- Specific information pertaining to – If you select this option, your description must be reasonably detailed. For example, “1/1/23 letter from Dr. Jane Doe.”
- Records requiring “special permission” – Please select the applicable checkboxes if you would like to release your mental health, substance use, genetic testing, or AIDS/HIV related information.

**Section 6: Additional Types of Disclosure**
Please note that while Columbia Health providers frequently request that individuals select one or both options, it is your choice.

**Section 7: Expiration Date**
All authorizations are valid for one year from your signature date. However, you may choose to enter a specific expiration date to shorten the validity of this authorization.

**Section 8: Signature of Patient or Authorized Representative**
You may sign and date this authorization electronically. If you are unfamiliar with using the electronic signature option, please refer to this helpful resource from Adobe. If you are unable to sign electronically, please print the authorization and physically sign and date it.