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.:** _____

Maiden or other name at time of service: _____

Date of Health Care Service:

From: (date) _____ To: (date) _____

PART 2 INFORMATION TO BE DISCLOSED

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

State and Federal laws protect the following information. I understand that, by checking the box(ex) below, this information will be disclosed to the party listed above. I also understand that this is a special authorization and is valid for 180 days (Ind Code 16-39-2) unless revoked in writing.

☐ AIDS, HIV Report ☐ Treatment for alcohol and / or drug abuse ☐ Mental Health Record

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

_____

_____

For the purpose of: _____

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 60 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**

(Indicate relationship if other than patient: ☐ Parent / Guardian ☐ Patient's Personal Representative)

_____ _____ ID Verified ☐ Yes ☐ No

Signature of Witness **Date**

PART 6 REVOCATION:

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

Person witnessing revocation: (sign and date): _____ _____

Any disclosure of Medical Record Information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.

This authorization complies with 45 CFR 164.508 and IC 16-39-1-4

MR-19 (05/16/2022)

COLUMBUS REGIONAL HOSPITAL
2400 EAST 17TH STREET, COLUMBUS, INDIANA 47201
1-800-841-4938 812-379-4441
www.crh.org

Authorization for Disclosure of Health Information

PATIENT LABEL

OR

Patient Name: _____

DOB: _____/_____/_____

MR #: _____