Columbia Heart
Experience. Compassion. Excellence.

Compound Authorization for Release of Information

PATIENT NAME _____ Date _____

Please check either "Yes" or "No" and initial each line. **Do you authorize Columbia Heart to:**

1. Mail medical reports through US Postal Service? ____ Yes ____ No _____Initial
2. Leave a message on Voice Mail? ____ Yes ____ No _____ Initial
   Cell Phone Number _____
3. Leave a message on Answering Machine? ____ Yes ____ No _____ Initial
   Home _____ Work _____
4. Give information to your employer? ____ Yes ____ No _____ Initial
   Name _____
5. Give information to your school? ____ Yes ____ No _____ Initial
   Name _____
6. Give information to your spouse? ____ Yes ____ No _____ Initial
   Name _____
7. Give information to your parents? ____ Yes ____ No _____ Initial
   Name _____
   Name _____
8. Give information to your children? ____ Yes ____ No _____ Initial
   Name _____
   Name _____
   Name _____
9. Give information to friends or others? ____ Yes ____ No _____Initial
   Name _____
   Name _____

Rights of the Patient

1. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by signing a written notification to **Columbia Heart HIPAA Officer.**
2. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
3. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
4. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Print Name of Patient _____

Patient Signature _____ Date _____

Witness Signature _____ Date _____

CH Employee _____ Time _____