



**Columbia Heart**  
*Empowering. Compassionate. Excellence.*

**COLUMBIA HEART  
AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize the use of disclosure of my individually identifiable health information as described below:

Patient name: \_\_\_\_\_ SS Number: \_\_\_\_\_  
DOB: \_\_\_\_\_

Persons/organizations providing the information:

Person/organizations receiving the information:

Columbia Heart  
8 Richland Medical Park Dr. Suite 200  
Columbia, SC 29203  
Phone (803) 258-6511  
Fax: (803) 771-7422

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check the box and initial to specify which type of information is to be disclosed.

- |   |       |            |       |             |       |
|---|-------|------------|-------|-------------|-------|
| <input type="checkbox"/> Medical Information  | _____ | Start Date | _____ | to End Date | _____ |
| <input type="checkbox"/> X-Ray Results        | _____ | Start Date | _____ | to End Date | _____ |
| <input type="checkbox"/> Lab Results          | _____ | Start Date | _____ | to End Date | _____ |
| <input type="checkbox"/> Progress Notes       | _____ | Start Date | _____ | to End Date | _____ |
| <input type="checkbox"/> Consultation Reports | _____ | Start Date | _____ | to End Date | _____ |
| <input type="checkbox"/> Other                | _____ | Start Date | _____ | to End Date | _____ |

Specify the records to be disclosed:

Purpose of the Disclosure: The disclosure is being made for the following reason(s):  At the request of the patient or  Other: \_\_\_\_\_

**Rights of the Patient**

I understand this authorization will expire on (check and complete one):  \_\_\_\_\_, \_\_\_\_\_, or  on the happening of the following event that relates to me or the purpose of the use or disclosure: \_\_\_\_\_

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 as described in this document by sending written notification to the practice at the above address.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

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.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Signature of patient or patient's representative  
(Form MUST be completed before signing)

Date

If signed by patient's representative:

Printed name of patient's representative: \_\_\_\_\_

Relationship to the patient (description of authority to act): \_\_\_\_\_

**Note: There may be a charge for a personal copy or the permanent transfer of your records. Health Port has been contracted to provide this service and will invoice you directly. The charge for copying your records starts at \$30.00. This is payable by cash or check.**

**Mail Form to: Columbia Heart  
ATTN: Medical Records Department  
8 Richland Medical Park Dr. Suite 200  
Columbia SC 29203**

Rev. 9/10/13