Columbia Heart

Experience Compassion 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) 256-6511
Fax: (803) 771-7422

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

o Medical Information	_____	Start Date	_____	to End Date	_____
o X-Ray Results	_____	Start Date	_____	to End Date	_____
o Lab Results	_____	Start Date	_____	to End Date	_____
o Progress Notes	_____	Start Date	_____	to End Date	_____
o Consultation Reports	_____	Start Date	_____	to End Date	_____
o 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 Date
(Form MUST be completed before signing)

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

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