

COLUMBUS OBSTETRICIANS – GYNECOLOGISTS, INC.

Authorization for Use or Disclosure of Protected Health Information

I authorize the release of medical records for:

Name of Patient: _____
(Include Maiden or Other Name(s) Used)

Date of Birth: _____ Social Security #: _____

To Be Released From: _____
(Physician's Name or Practice Name)

(Address: Street, City and State)

To Be Sent To: _____
(Physician's Name or Practice Name)

(Address: Street, City and State)

Medical Records Requested: _____

Date(s) of Service: _____

Purpose: _____ Transfer of Care _____ Continuity of Care _____ Personal Use

This authorization shall be in force and effect until {specify (1) a date certain or (2) event that relates to the patient or the purpose of the use or disclosure at which time this authorization to use or disclose this protected health information expires. ("End of the research study" and "none" is acceptable for authorization for research purposes)} Effective until: _____

I understand that I have the right to revoke this authorization, in writing, at any time, by sending such written notification to the practice's Privacy Officer at 750 Mt. Carmel Mall, Suite 100, Columbus, Ohio 43222 or by e-mail at mvanmeter@columbusobgyn.com. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative

Date