



Authorization for Release of Protected Health Information to CMP

Patient Name: _____ Date of Birth ___ / ___ / ___
 (First) (Middle Initial) (Last)
 Street Address: _____ Phone # _____
 City: _____ State _____ Zip Code: _____

I hereby authorize _____ to release the protected health information (PHI) to
 Columbia Medical Practice for the identified dates of service from: ___ / ___ / ___ to
 ___ / ___ / ___ .

Information to be released:

- Complete Medical Record Radiology Reports Only
 Laboratory Reports Only Other: _____

Information to be excluded:

I understand that this authorization includes permission to release any PHI in my health record relating to the history, diagnosis, testing/results, or treatment that I may have received for sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, or treatment of alcohol, drug or substance abuse.

Check "Do Not Release" to exclude this information.

Category	Do Not Release
Alcohol, Drug or Substance Abuse	<input type="checkbox"/>
Behavioral/Mental Health	<input type="checkbox"/>
Acquired Immunodeficiency Syndrome (AIDS)	<input type="checkbox"/>
Human Immunodeficiency Virus (HIV)	<input type="checkbox"/>
Sexually Transmitted Disease (STD)	<input type="checkbox"/>

Purpose:

- Changing physician Consultation/ second opinion Legal
 School Insurance Other: _____



Released From:

Name: _____

Organization: _____

Street _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

Specify Disclosure Format: Default = Secure Internet Download/PDF if not shown otherwise

- Secure Internet Download/PDF
CD/Electronic/PDF for Mail or Pickup
Fax (Healthcare provider office only)
Paper for Mail or Pickup

By signing this authorization form, I understand that:

- 1. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to: Columbia Medical Practice - Administration, 5450 Knoll North Drive, Suite 180, Columbia, Maryland 21045.
2. Revocation will not apply to information that has already been disclosed in response to this authorization.
3. Unless otherwise revoked, this authorization will expire one year from the date signed.
4. Any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.
5. Requests for copies of records are subject to preparation and copying fees in accordance with federal/state regulations.
6. Columbia Medical Practice may not condition your receipt of treatment on your signing of this Authorization.

Authorizing Party: I hereby authorize Columbia Medical Practice to release the PHI listed above from the medical records.

Signature _____ Date _____

Please complete if not the patient:

Name: _____ Relationship: _____

Signature _____ Date _____