Columbia Women's Healthcare

tending to the unique nature of women

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

Columbia Women's Healthcare is authorized to release protected information about the above named patient to the entities below. The purpose is to inform the patient or others in keeping with the patients' instructions.

Emergency Contact: _____ Relationship to patient: _____ Phone: _____

Information that can be left on patient's voicemail (Circle all that apply)

Test Results (Any) **Appointment Information** **Billing/Financial/Insurance** **Medical (Instructions/Directions)**

(Please give the full name of anyone who is able to receive information about you)

Description of Information to be released	Entity to Receive Information	Relationship to you
1. Results of Lab Tests/Ultrasound/X-Ray	_____	_____
2. Scheduled Appointment Information	_____	_____
3. Billing, Financial, and Insurance Information	_____	_____
4. Medical Information from Office Chart/Record	_____	_____
5. Demographic Information	_____	_____

Rights of the Patient:

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 sending a written notification to Columbia Women's Healthcare. I understand that a revocation is not effective in cases where information has already been disclosed, but will be effective going forward.

_____ _____

Signature of Patient or Personal Representative **Date**

Description of Personal Representative Authority (attach necessary documentation)