

# Authorization to Release Confidential Health Records

*Please print legibly*

Individual/ Patient's Name (first name/middle initial/last name):	
Parent or Guardian's Name:	
Health Care Entity's Name:	Columbia Associates in Psychiatry
Person, Agency or Health Care Entity to whom disclosure is to be made:	Name:  Address:  Phone number:
Information or Health Records to be disclosed:	
Purpose of Disclosure or at the Request of the Individual:	
<p>As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records.</p> <p>I hereby authorize the health care entity noted above to release the information in my (or my child's) health records, including, but not limited to diagnoses, treatment information, and other notations.</p> <p>I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization.</p> <p>I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization.</p> <p>A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.</p> <p>I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.</p>	
This authorization expires on (date) or (event):	
Signature of Individual/ Patient or Parent/Guardian or Individual/ Patient's Legal Representative:	
Printed Name:	
Relationship or Authority of Legal Representative:	
Date of Signature:	