



Lower Lights Medical Records
777 West State Street, Ste, 201a, Columbus, Ohio
Phone: 614-274-1455; Fax: 614-274-1433

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name (PRINT CLEARLY) _____ DOB ____/____/____
Address _____ City _____ State _____ Zip _____
Phone # _____ Email Address _____

Physician/Practice/Organization Authorized
to SEND Information

Physician/Practice/Organization Authorized
to RECEIVE Information

Name _____
Address _____
City/State/Zip _____
Phone#: _____ FAX#: _____

Name: Lower Lights Christian Health Center, Attn Medical Records
Address 777 W. State Street, Ste.201 A
City/State/Zip: Columbus, OH 43222
Phone#: 614-274-1455 FAX#: 614-274-1433

INFORMATION TO BE RELEASED

- Most recent medication list
Immunization Record
Mammogram
Last Office Notes
Laboratory Reports
Colonoscopy Report
Other
Records from until
Radiology Reports
PAP with cytology
OB/ Prenatal Records

Dates of Service Requested:

Delivery Type:

- Most Recent
From to
ALL
FAX
MAIL

I understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the Privacy Officer at this site of care, except to the extent that action has already been taken to release this information. I have a right to inspect a copy of the health information to be released. I understand that this authorization is voluntary and I may refuse to sign this authorization. The above named person/institution will not refuse to treat me based on whether I allow my health information to be used and disclosed by others. I understand that the information I authorize a person or entity to receive maybe re-disclosed and no longer protected by federal privacy regulations. I understand that this authorization is voluntary and may include sensitive information relating to AIDS/HIV infection, behavioral health services/psychiatric care, treatment for alcohol/substance abuse in non-confidential problem summaries and/or documents in my medical record, even if not specifically designated above. This authorization shall remain valid for one year unless revoked .

Patient Signature _____ Date _____

Parent/Legal Guardian/Representative _____

Relationship to Patient _____

Witness Signature _____