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

INFORMATION TO BE RELEASED

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

Dates of Service Requested:

O Most Recent **O** From___________to_____________ **O** ALL

Delivery Type:

O FAX **O** 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____