



Columbus Endocrine
CONSULTANTS

Authorization For Use & Disclosure Of Protected Health Information

This authorization is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights to privacy with respect to your health care information. It authorizes Columbus Endocrine Consultants (CEC) to disclose your medical records to the entity(ies) listed below.

Patient Name: _____ DOB: _____

Address: _____

Information to be released (eg. History, Labs, Imaging, etc.): _____

Release to the following entity(ies):

Name: _____

Phone: _____ Fax: _____

Address: _____

I understand that under the privacy rules, I have the right to revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. This authorization will expire automatically 60 days from the date on which it is signed. If I choose to revoke this authorization sooner I must do so in writing to:

Columbus Endocrine Consultants
6790 Perimeter Drive, Suite 200
Dublin, OH 43016

I understand that by disclosing these records, CEC cannot guarantee that the recipient will not re-disclose or use the records in a way that violates the privacy rules.

Patient/Guardian Signature _____ Printed Name _____

Relationship to patient (if guardian) _____

Date _____

Columbus Endocrine Consultants
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