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 the entity listed below to disclose your medical records to Columbus Endocrine Consultants (CEC).

Patient Name: _____ DOB: _____

Address: _____

_____

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

_____

Release from 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 to CEC the practice 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 _____