COLUMBUS COMMUNITY HOSPITAL, INC.
4600 38th Street, PO Box 1800
Columbus, NE 68602-1800

AUTHORIZATION TO RELEASE MEDICAL RECORDS

MR-1 12/14

I authorize Columbus Community Hospital to release the following information on

_____
Patient's Name & Date of Birth

to:_____
Name and Address

Date(s) of Treatment_____& Information to be Disclosed:

☐ Discharge Summary	☐ ER Record	☐ Lab & X-ray Reports
☐ Operative Report	☐ Progress Notes	☐ H & P
☐ X-ray Films	☐ Consult Report	☐ Complete Record

Purpose for which information is to be used:

☐ Treatment	☐ Insurance	☐ Personal
☐ Follow Up	☐ Legal Proceedings	☐ Other: _____

I specifically authorize the release of information relating to:
__Substance abuse (including alcohol/drug abuse)
__Mental health
__HIV/AIDS related information (including test results)

I understand and acknowledge:

1. My refusal to sign this authorization will not affect my ability to obtain treatment at Columbus Community Hospital.
2. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by State or federal law.
3. This authorization is effective for 12 months after the date it was signed. I understand that I may revoke this authorization at any time by contacting HIM Department at CCH. My revocation will not be effective to the extent action has already been taken in reliance on my authorization.
4. I have read (or had read to me) and have received a copy of this document. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as the original.

_____ _____ AM / PM
Patient or person authorized to sign for patient/relationship Date/Time

_____ _____ AM / PM
Witness to signature only Date/Time

NOTICE OF REVOCATION

I _____, submit this form as a Notice to revoke the authorization
Patient Name/Representative

I previously submitted on _____. This is to become effective on _____.
Date Date