Authorization for Communication & Release of Health Information

Patient Name:_____ Date of Birth: _____

AUTHORIZATION

Patients, and parents or legal guardians of minor patients, may choose to allow other trusted adults to discuss medical or billing information, request prescriptions, obtain vaccine information, or access medical records and test results on their or their child's behalf. Under the Health Insurance Portability and Accountability Act (HIPAA), we cannot share a patient's protected health information with anyone beyond the patient or their legal guardian without proper authorization. If you would like us to communicate with and release any medical information to a family member, friend, or other designated individual, please complete and sign this authorization form.

USE & DISCLOSURE OF HEALTH INFORMATION

I, as the patient or parent/legal guardian of the above-named minor patient, authorize Central Ohio Primary Care (COPC) to release medical records and any requested health information to the following individuals:

Name	Phone Number	Relationship

- I understand a separate authorization form must be signed to release copies of the patient's medical record to any individual not authorized on this form.
- I understand this authorization approves the release of all medical information, which will include treatment for physical and mental illness, sensitive tests and results including but not limited to information concerning testing, diagnosis, and treatment of HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immunodeficiency Syndrome) that may be in the patient's medical record.
- I understand I have the right to withdraw this authorization at any time by submitting a written request to the patient's COPC clinic. Any disclosures COPC has already made before receiving the written withdrawal request will not be affected.
- I understand this permission remains in effect for two years from the date of signature, unless a written withdrawal is submitted to COPC.

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SIGNATURE

By signing this document, you agree that you have read, received, and understood all parts of this document and consent to the disclosure of your medical information to the person(s) listed above.

Patient Signature:_____ Date Signed: _____

PATIENT REPRESENTATIVE

If you are a patient representative, sign and date this form below. Please check the box that describes your relationship to the patient. If you are not the parent of the patient, we need proof of your relationship for our records (i.e., power of attorney, personal representative documentation, etc.).

Patient Representative (Printed): _____

Patient Representative Signature: _____ Date: _____

☐ Parent of minor child ☐ Legal Guardian ☐ Power of Attorney ☐ Executor ☐ Other: _____