By signing this authorization, I authorize COLUMBUS GYNECOLOGY & ADULT MEDICINE to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

Authorized to Release:	Authorized to Receive:
_____	_____
Releasing Information	To Receive Information
_____	_____
Address	Address
_____	_____
City / State / Zip	City / State / Zip

This authorization permits COLUMBUS GYNECOLOGY & ADULT MEDICINE to use or disclose copies of the following individually identifiable health information:

_____ Contents of entire medical record including information on drug, alcohol, mental health and infectious disease.

_____ Contents but exclude information on drug, alcohol, mental health and infectious diseases.

_____ Contents but exclude information from any other doctors, facilities, etc.

_____ Other (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)

for the purpose of:_____

I understand this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. This consent will expire in 60 days.

Indiana Code #760IAC 1-71-2 provides a written request may be made and provided to you in a specified manner for an appropriate fee, therefore, I understand and agree that I am financially responsible for fees of $20.00 (1-10 pgs), $0.50 per pg for pages 11-50, $0.25 per pg for pages greater than 51; The actual cost of mailing the medical record; An additional $10.00 will be charged if the records are to be provided within 2 working days; If records are mailed certified there will be an additional $20.00 charge.

I understand this facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent and authorized herein.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except to the extent that COLUMBUS GYNECOLOGY & ADULT MEDICINE has acted in reliance upon this authorization.
COLUMBUS GYNECOLOGY & ADULT MEDICINE'S Privacy Officer at 2326 18TH Street, Ste 210 Columbus, Indiana 47201 PHONE: 812-372-8426 FAX: 812-378-7777

Patient Information & Authorized Signatures:

_____	_____	_____
Print Name of Patient	Date of Birth	Relationship to Patient
_____	_____	
Signature of Patient/Legal Guardian	Address	
_____	_____	
Print Name of Legal Guardian	City / State / Zip	
	_____	
	Date	

For Office Use:
Action Taken: _____ Date: _____ Staff Name: _____