COLUMBIA HEALTH

AUTHORIZATION FOR VERBAL DISCLOSURE OF HEALTH INFORMATION

Please send this form to:

For Counseling and Psychological Services	***For Medical Services***	***For Disability Services***
Alfred Lerner Hall, 8th Floor	*John Jay Hall, 3rd and 4th Floor*	*Wien Hall, Suite 108*
2920 Broadway, MC 2606	*519 West 114th St., MC 3601*	*411 W. 116th St., MC 3714*
New York, NY 10027	*New York, NY 10027*	*New York, NY 10027*
Fax: (212) 854-9473	*Fax: (212) 854-9851*	*Fax: (212) 854-3448*

Patient Name: (Print) _____ Uni:_____

This Authorization grants permission for verbal disclosure of the information identified below to:

Name: (Print)_____ Relationship to Patient: _____

Phone: _____ Fax/email: _____

Please check the box to authorize the disclosure of the information (please initial)

_____Mental health records _____Billing & insurance information

_____Medical health records _____Appointment Information

_____Alcohol/drug abuse treatment _____Other (please specify): _____

I authorize Columbia Health to use and disclose my health information as described in this authorization.

- I understand that this information will expire 1 year from the date signed by the patient or when revoked by the patient unless a different expiration is specified below
- I understand that I may revoke this authorization at any time by notifying in writing the clinician/program
- If I do revoke the authorization, it will not have any effect on any actions taken by the clinician/program prior to their receipt of the revocation
- I understand that this authorization is voluntary and that my treatment cannot be conditioned on whether I sign this authorization
- I understand that once this information is released , the released information may no longer be protected by federal privacy regulations

This authorization will expire: (please initial) If not stated, authorization will expire in one year

_____At the end of my treatment _____Obtain a new authorization prior to each disclosure

_____When I am no longer a patient _____Other - _____

By signing this document, I am authorizing the verbal disclose as stated above.

_____ _____

Signature of patient or patient's representative Date

(Form MUST be completed before signing or will not be valid)