



**AUTHORIZATION FOR VERBAL DISCLOSURE OF HEALTH INFORMATION**

Please send this form to:

<b>For Counseling and Psychological Services</b> Alfred Lerner Hall, 8th Floor 2920 Broadway, MC 2606 New York, NY 10027 Fax: (212) 854-9473	<b>For Medical Services</b> John Jay Hall, 3rd and 4th Floor 519 West 114th St., MC 3601 New York, NY 10027 Fax: (212) 854-9851	<b>For Disability Services</b> Wien Hall, Suite 108 411 W. 116 <sup>th</sup> St., MC 3714 New York, NY 10027 Fax: (212) 854-3448
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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  
(Form MUST be completed before signing or will not be valid)

\_\_\_\_\_  
Date