AUTHORIZATION FOR RELEASE OF INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION TO DESIGNATED PARTY

This form releases the authorization for a family member of your choice to have access to the following information:

This authorization grants permission to the designated party to:

I, _____ authorize permission to the
(your name)
designated party to:

_____ have access to my medical records, including test results

_____ have access to my billing information

_____ make and confirm appointments

_____ other, Please specify _____

I hereby authorize the following Columbia University Physician Practice to use and disclose my individual identifiable health information as described above:

Physician: _____

Department of Surgery

Person authorized to share your information:

_____ _____
(name of designee) (relationship)

I understand this authorization will (must check one)

_____ expire one year from the date signed by the patient

_____ be effective for the lifetime of the patients unless revoked

I understand that my treatment cannot be conditioned on whether I sign this authorization

_____ _____
Signature of Patient or Representative Date