ColumbiaDoctors

Pathology & Cell Biology

Release of Information Authorization

To: Columbia University
Department of Anatomic Pathology, Slides Sent-Out
622 West 168th Street, VC-14th Floor, Rm. 241
New York, NY 10032 Tel. #: (212) 305-0958 Fax #: (212) 305-5912

Note: There is a $80.00 processing fee for slides. Payment can be made with Credit Card, Money Order or Personal Check. Please call to arrange payment.
I understand that I am 100% financially responsible for all charges for services to me including copay and the balance remaining after payment of possible insurance benefits. Please initial _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name:

_____

Date of Birth:

_____ **Phone number** _____

Patient Address:

_____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA),I understand that:

1.
This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8

2.
If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

3.
I have the right to revoke this authorization at any time by writing to the address above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4.
I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5.
Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.

6.
THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

7. Name and address of health provider or entity to release this information:
Columbia University Medical Center Department of Pathology & Cell Biology, 622 W 168St VC-14 241 NY,NY 10032

8. Name, address and phone number of person(s) or category of person to whom this information will be sent:

_____

9(a). Specific information to be released:

Pathology slides/Pathology Report ☐ **Pathology Report Only** ☐

(b) By initialing here _____ I authorize _____ Initials
Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Date or event on which this authorization will expire: _____

_____ _____

Patient signature or legal authority _____ **Date** _____