ColumbiaDoctors

Marketing or Sale
Authorization for Release of Patient Information

Patient Name: ________________________________ Date of Birth: __________________

Address: ________________________________ Phone: ___________________

I authorize the release of the following medical information: ___________________________

The purpose of this release:

□ To provide me with information about medical products or services

□ Other (specify) ____________________________

□ Yes □ No I understand that Columbia University will be receiving direct or indirect financial or non-financial remuneration in exchange for the disclosure of this information.

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as described above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information is released by providing written notice of revocation as specified in the Notice of Privacy Practices, except to the extent that action has already been taken based on this authorization.
- If the receiving party is not subject to medical information privacy laws, the information may be re- disclosed by the recipient and may no longer be protected by federal or state law.
- Columbia University shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS an additional release of medical information form will be requested.
- This Authorization expires on______________{one year after signed if not completed}
  Date

_________________________________ ___________________________

Patient / Representative Signature **Date**

If the patient listed above is a minor or is unable to sign and you are the parent or legal guardian signing on behalf of this patient, please sign above and complete the following information:

_________________________________ _________________________________

Print Name **Relationship to patient**

Retain this form in the patient's medical record and provide a copy to the patient

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.