Columbia Counseling Center
COMPREHENSIVE PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

Authorization to release Medical Records Form

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Authorization to Disclose/ Release Medical Record Information

I, _____, authorize Columbia Counseling Center to

Please Circle One: disclose my Medical Record information to **OR** obtain information from:

Provider / Organization Name:
_____

Address: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number:
_____

Provider's at Columbia Counseling Center to whom I am requesting records from:
_____

Information to be obtained / Received:

☐ Treatment Summary ☐ Assessment / Evaluation ☐ Psych/Neuro Testing Report

☐ Progress Notes ☐ All Medical Information ☐ Psychotherapy Notes

☐ Discharge Summary ☐ Other: _____

Information to be Discussed / Shared:

☐ Medical Form/s ($25 per page) ☐ Medical Records (MD law guidelines)

☐ Medical Letter/s ($25 half page - $100+) ☐ Submit to above on my behalf (+$22.88 processing fee)

☐ Patient Pick Up ($0.76 per page ONLY)

By signing below, I agree to the above Medical Record charges and the disclosure of my health information to whom I have listed. All fees for Medical Records are due before the release of any information. I have been made aware that I am responsible for 100% of all fees associated with my request/s including those that I do not pick up/ no longer need and those that are not covered by my requested organization.

_____ _____ _____
Patient / Guarantor Signature Printed Name Date

Relationship to Patient (if Guarantor completing form): _____

_____ _____
Columbia Counseling Center Staff Witness Date