Columbia Counseling Center
COMPREHENSIVE PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

# Authorization of Health Disclosure Form

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

## Authorization to Disclose Health Information

**I,** _____, grant permission for the following person(s) to:

1. Obtain / discuss information regarding my care.
2. Speak with the provider, and/or staff on my behalf.
3. Pick up any information regarding the patient listed above including prescriptions.
4. Make / Cancel / Reschedule appointments
5. Discuss financial matters
6. Other: _____

| **Name of person disclosing information to:** | **Relationship to the patient:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I hereby **DECLINE** the following permissions for the following person(s):

- Name: _____ Permission Declined: 1 2 3 4 5 6
- Name: _____ Permission Declined: 1 2 3 4 5 6
- Name: _____ Permission Declined: 1 2 3 4 5 6
- Name: _____ Permission Declined: 1 2 3 4 5 6

_____ _____ _____
**Patient / Guarantor Signature** **Printed Name** **Date**

**Relationship to Patient (if Guarantor completing form):** _____

_____ _____
**Columbia Counseling Center Staff Witness** **Date**