



AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
614-228-6289 (fax) 614-864-2248 (fax)

PATIENT NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

PATIENT ADDRESS _____ PATIENT TELEPHONE NUMBER _____

PLEASE CIRCLE THE COSA SURGEON(S):

- | | | | |
|------------------------|----------------------|---------------------------|---------------------|
| Irina Arp, MD | Thomas M. Vara, MD | Fernando Aguila, MD | James M. Sinard, MD |
| Jeffrey L. Turner, MD | Jason C. Keith, MD | Marcus R. Miller, MD | Chazz Dabbs, MD |
| Lowell W. Chambers, MD | Kristine D. Slam, MD | Adam M. Zochowski, MD | Greg Holland, MD |
| Steven C. Reitz, MD | Kevin Radecki, MD | Christopher Zochowski, MD | Maurice P Page, MD |

I HEREBY REQUEST AND AUTHORIZE CENTRAL OHIO SURGICAL ASSOCIATES TO RECEIVE FROM OR FURNISH RECORDS TO:

FOR THE PURPOSE OF: _____, CONTINUED CARE, OR AT MY REQUEST.

Please release the following information (please check or circle):

- | | | |
|---|---|-------------------------|
| <input type="checkbox"/> ALL COSA MEDICAL RECORDS | <input type="checkbox"/> COSA Provider Notes | Dates of Service: _____ |
| | <input type="checkbox"/> COSA Operative Report(s) | Dates of Service: _____ |
| | <input type="checkbox"/> COSA Lab /Test Result(s) | Dates of Service: _____ |
| | <input type="checkbox"/> COSA Radiology Report(s) | Dates of Service: _____ |
| | <input type="checkbox"/> COSA Billing Record(s) | Dates of Service: _____ |

OTHER (please specify documents and dates of service): _____

UNLESS I HAVE LIMITED BELOW, I understand that this also pertains to records regarding testing and treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AIDS, for psychiatric treatment or counseling, or communicable disease. Please specify any limitations: _____

By SIGNING BELOW, I UNDERSTAND (1.) I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it; (2.) This authorization will expire in 60 Days from the date signed, unless I specify otherwise; (3.) COSA is not responsible for any further disclosures made by the Recipient of Records that will then no longer be protected by the Federal Privacy Regulations; (4.) This authorization is voluntary and my refusal to sign this authorization will not affect my treatment, payment, or healthcare operations; and (5.) I am entitled to ask for a copy of this document and may inspect a copy of my records used or disclosed **under this authorization**.

Date: _____ Signature: _____
(Patient)

Expiration (If not at 60 days): _____ Signature: _____

CENTRAL OHIO SURGICAL ASSOCIATES, INC USE ONLY:
RELEASED BY: _____ DATE: _____ FEES ASSESSED: Y N FILE:CORRESPONDENCE -092012