CENTRAL OHIO SURGICAL ASSOCIATES, INC.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FAX TO (614) 864-2248

PATIENT NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

PLEASE CIRCLE YOUR COSA SURGEON(S):

—Fernando N. Aguila, MD	**—Thomas M. Vara, MD**	**—Maurice P. Page,MD**
—Jeffrey L. Turner, MD	**—Jason C. Keith, MD**	**—Marcus R. Miller, MD**
—Lowell W. Chambers, MD	**—Kristine D. Slam, MD**	**—Adam M. Zochowski, MD**
—Steven C. Reitz,MD	**—Charles Dabbs, MD**	**—Daniel Hall, MD**

I HEREBY REQUEST AND AUTHORIZE CENTRAL OHIO SURGICAL ASSOCIATES, INC. TO (CIRCLE ONE) 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):

☐ ALL COSA MEDICAL RECORDS

☐ COSA Provider Notes Dates of Service:_____

☐ COSA Operative Report(s) Dates of Service:_____

☐ COSA Lab /Test Result(s) Dates of Service:_____

☐ COSA Radiology Report(s) Dates of Service:_____

☐ 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 (I.) 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:_____
(Parent/Guardian/Legal Representative)

_____

CENTRAL OHIO SURGICAL ASSOCIATES, INC USE ONLY:

RELEASED BY: **DATE:** **FEES ASSESSED: Y N FILE:CORRESPONDENCE-DISCLOSURES ACCOUNTING**