December 13, 2019

To Our Columbus Women's Care Family,

We are announcing that **Dr Francisco Sosa** will be leaving our practice this December. Dr Sosa has been a welcome addition to our practice during his tenure, but this chapter is coming to a close and he will be missed. Dr Sosa will be taking a teaching position within the Trinity Health/ Mt Carmel System.

Columbus Women's Care INC. as an organization and corporation has been proud to have served the Columbus community for well over 70 years and that commitment and **"calling"** will not change. **OUR DOORS REMAIN OPEN TO SERVE YOU with the same care, compassion, and concern you have come to expect from our office.**

Carol Thomas CNM.WHNP., Patricia Baumann CNM, and I remain steadfast in our commitment to your feminine health needs and the health and wellbeing of your babies that are on the way :) Our team is experienced, cohesive, calm, caring, and devoted to the care of our patients.

For those Patients that would like to transfer to another practice we will work with you to transfer your records. On our website is a downloadable medical records release form that you simply need to fill out and then fax ,mail, or drop off at the office. For those patients that enjoy the convenience of our location or the practice environment we foster in our office you are welcome to stay with us and we will continue your care with a seamless transition.

Dr Cherie Alandra Richey C.E.O

"To exist is to change, to change is to mature, to mature is to go on creating oneself endlessly."

-Henri Bergson-

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

PATIENT NAME ________________________ DATE OF BIRTH ________________________

PHONE (C) ________________________ PHONE (W) ________________________

ADDRESS ________________________ CITY/STATE/ZIP ________________________

PLEASE NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

ABOVE LISTED PATIENT AUTHORIZES THE FOLLOWING HEALTHCARE FACILITY TO MAKE RECORD DISCLOSURE:

FACILITY NAME ________________________ FACILITY PHONE ________________________

FACILITY ADDRESS ________________________ FACILITY FAX ________________________

CITY/ STATE/ ZIP ________________________

DATES AND TYPES OF INFORMATION TO DISCLOSE:

☐ 2 YEARS PRIOR FROM LAST DATE SEEN

☐ DATES OTHER: ________________________

☐ SPECIFIC INFORMATION REQUESTED: ________________________

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THE PURPOSE OF DISCLOSURE:

☐ CHANGE OF INSURANCE OR PHYSICIAN

☐ CONTINUATION OF CARE (E.G., VA MED CTR)

☐ REFERRAL

☐ OTHER ________________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I UNDERSTAND THE INFORMATION IN MY HEALTH RECORD MAY INCLUDE INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASE, AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES, AND TREATMENT FOR ALCOHOL AND DRUG ABUSE.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

RELEASE TO ________________________

ADDRESS ________________________

CITY/ STATE/ ZIP ________________________

FAX# ________________________ PHONE ________________________

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I RECOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE HEALTH INFORMATION MANAGEMENT DEPARTMENT. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN REPSPONSE TO THIS AUTHORIZATION. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER MY POLICY. **UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION: ________. IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT, OR CONDITION, THIS AUTHORIZATION WILL EXPIRE 1 YEAR FROM THE DATE SIGNED.**

I UNDERSTAND THAT AUTHORIZING THE DISCLOSURE OF THIS HEALTH INFORMATION IS VOLUNTARY. I CAN REFUSE TO SIGN THIS AUTHORIZATION. I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I UNDERSTAND THAT I MAY INSPECT OR OBTAIN A COPY OF THE INFORMATION TO BE USED OR DISCLOSED, AS PROVIDED IN CFR 164.524. I UNDERSTAND THAT ANY DISCLOSURE OF INFORMATION CARRIES WITH IT THE POTENTIAL FOR AN UNAUTHORIZED REDISCLOSURE AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES. IF I HAVE QUESTIONS ABOUT DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT THE AUTHORIZED INDIVIDUAL OR ORGANIZATION MAKING DISCLOSURE.

I HAVE READ THE ABOVE FOREGOING AUTHORIZATION FOR RELEASE OF INFORMATION AND DO HEREBY ACKNOWLEDGE THAT I AM FAMILIAR WITH AND FULLY UNDERSTAND THE TERMS AND CONDITIONS OF THIS AUTHORIZATION.

X ________________________ **DATE** ________________________

SIGNATURE OF PATIENT/PARENT/GUARDIAN OR AUTHORIZED REPRESENTATIVE (GUARDIAN OR AUTHORIZED REPRESENTATIVE MUST ATTACH DOCUMENTATION OF SUCH STATUS)

X ________________________ RELATIONSHIP/CAPACITY OF PATIENT ________________________

PRINTED NAME OF AUTHORIZED REPRESENTATIVE

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ADDRESS AND PHONE NUMBER OF AUTHORIZED REPRESENTATIVE

***PLEASE MAIL RECORDS IF MORE THAN 20 PAGES* REQUESTING PROVIDER: ________________________**