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Colon and Rectal Surgery

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize _____ to release health information on:
Name of Provider

Patient Name:_____ Date of Birth:_____
Address:_____ Social Security #:_____

Telephone:_____

For Healthcare Covering the Period(s) From:_____ To:_____

Other Healthcare provider records (specify):_____
To: Name _____ Telephone:_____

Address:_____
I Do Do Not (circle applicable answer) Authorize this information to be faxed. If yes,
Fax Number:_____
Name of Person to Receive Information_____

I understand this information may contain information relating to:
Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency virus), Mental Health, Alcohol and/or Drug Abuse.

REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION FOR THE PURPOSES STATED ABOVE.

UNLESS OTHERWISE INDICATED, THIS AUTHORIZATION WILL EXPIRE NINETY(90) DAYS FROM THE DATE OF SIGNATURE. THE PHYSICIAN AND EMPLOYEES ARE RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT IDICATED AND AUTHORIZED HEREIN.

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I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date

If Alcohol & Drug Abuse Records. This information may have been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from mailing any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical and other records information is NOT sufficient for this purpose.

Original of copy of this authorization shall be field in the patient's medical record.