THE CENTER FOR COLON AND DIGESTIVE DISEASE

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Authorization to Release Medical Records/Information

Physician to provide records: _____

Patient's Name: _____

Social Security # _____ DOB: _____

Person/Facility to receive records: _____

Address: _____

City, State, Zip: _____

Records to release (enter your initials):

Initials	**Records:**
_____	All medical records at this facility
_____	Only records generated by this facility (not including records received from other sources)
_____	Only some portion of records maintained at facility (dates of treatment, etc., please specify)

_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency or individual named on this request with the EXCEPTION OF:

Initials	
_____	Substance abuse, if any
_____	AIDS/HIV, if any
_____	Psychological or psychiatric conditions, if any
_____	Other (please specify) _____

_____

Expiration or revocation of authorization - I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient Name (print):

_____

_____

Patient Signature

Date: _____/_____/_____

Person authorized to sign for patient (print):

_____

_____

Signature

Date: _____/_____/_____