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AUTHORIZATION FOR THE RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:____ Date of Birth: _______________

Address: ____

Telephone #: ____

The above patient listed hereby gives permission to the Colorectal Health Northwest to (*check one*):

☐ **Release Protected Health Information to:**
☐ **Obtain Protected Health Information from:**

Name:____

Address:____

Phone:______________________________________ Fax:_____________________________

I expressly request that the designated record custodian disclose full and complete protected health information including the following **(initial each item to be included):**

NOTE: ONLY THOSE ITEMS INITIALED WILL BE INCLUDED IN THE RELEASED INFOMATION

_____ All hospital records (Date Range ____________ to___________)
_____ Clinician office chart notes
_____ Medical records needed for continuity of care
_____ Lab reports ______________________________________
_____ Operative reports __________________________________
_____ Pathology reports__________________________________
_____ Diagnostic imaging reports ___________________________

Federal Regulation 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed. Provide a specific description of information on reverse of this form

_____ HIV/AIDS related records
_____ Genetic testing information
_____ Drug/alcohol diagnosis, treatment or referral information as listed on back

This release will expire in 180 days. I understand that I sign this form voluntarily and that I may change my decision at any time. Although I understand that I cannot do anything about information previously authorized in release, I am aware that I must notify Colorectal Health Northwest in writing if I would like to revoke this release. A copy of this form is as valid as the original.

____ ________________________
Authorizing Signature Date