Colorectal Health Northwest

Providence St. Vincent Medical Center
9155 SW Barnes Rd. Suite 231
Portland, OR 97225

Office 503-216-5380
Fax: 503-216-5399
www.nwcch.com

Scott M. Browning, MD, FACS, FASCRS
Megan M. Cavanaugh, MD, FACS, FASCRS
Jeffrey V. Manchio, MD, FACS
Lisa S. Poritz, MD, FACS, FASCRS
Colon and Rectal Surgeons

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