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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 INFORMATION

- 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