



Colon & Rectal Specialists, Ltd.

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security # _____

I request and authorize (name of physician or medical practice): _____

To release health care information of the patient named above to:

Name of individual or entity to receive the information: _____

Address: _____

City, State & Zip Code: _____

This authorization form applies to the following specific information: _____

This protected health information is being used or disclosed for the following purposes: _____

This authorization expires on: (date): _____ or when the following event occurs: _____

I understand that I have the right to revoke this authorization, in writing, at any time, but that a revocation is not effective to the extent that Colon & Rectal Specialists, Ltd. has relied on my authorization. I understand that to revoke this authorization, written notification should be sent to: Colon & Rectal Specialists, Ltd. • 7605 Forest Avenue, Suite 308 • Richmond, Virginia 23229-4936

I understand that once this information is released by Colon & rectal Specialists, Ltd., the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law. Option #1: I understand that Colon & Rectal Specialists, Ltd. will not condition my treatment on whether I provide authorization for the requested use or disclosure. Option #2: I understand that the treatment requested from Colon & Rectal Specialists, Ltd. is conditioned on my signing this authorization because this treatment is for the sole purpose of providing specific information to the party named above.

If applicable, signing this authorization may result in permission for my physician to receive direct or indirect payment from a third party based on the use or disclosure of my medical information.

Signature of patient or personal representative: _____ Date: _____

Name of patient or personal representative: _____

Description of personal representative's authority: _____

PROVIDE THE PATIENT A COPY OF THIS SIGNED FORM.