

COLON AND RECTAL CLINIC, P.A.  
AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, \_\_\_\_\_  
(Full name of patient) (DOB) (SSN)  
\_\_\_\_\_  
(Address, City, State, and Zip Code)

Authorize Colon and Rectal Clinic, P.A. to release my medical records to:

Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone # \_\_\_\_\_  
Fax # \_\_\_\_\_

Please check what information it to be released:

Doctor's Notes       Test Reports       Mental Health  
 HIV Test Results       Other Specify \_\_\_\_\_

I hereby release Colon and Rectal Clinic, P.A. from any legal responsibility and liability that may arise from this authorization.

I understand that the information in my record may include information relating to HIV of AIDS. It may also include information about behavioral, mental health and or substance abuse.

I understand that I may revoke this authorization at any time and that I must do so in writing to the party releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

The patient agrees that a photocopy of this authorization may be considered valid  
yesno

\_\_\_\_\_  
Signature of Patient      Printed Name      Date

\_\_\_\_\_  
Witness      Printed Name      Date

