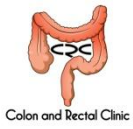

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

I, _____, hereby authorize Colon and Rectal Clinic to release my/my dependent's medical information to _____

Name of the health care facility, physician, agency etc

Address: _____

Number Street Suite # City State Zip Code

Phone # _____ Fax # _____

Please check what information it to be released:

❑The entire medical record, including mental health, treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS)

❑ Doctor's Notes ❑Test Reports ❑ Mental Health

❑Operative notes ❑ Others, Specify_____

I hereby release Colon and Rectal Clinic, from any legal responsibility and liability that may arise from this authorization. I understand that the information in my record may confidential information including information relating to HIV of AIDS. It may also include information about behavioral, mental health and or substance abuse. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and my no longer be protected by law.

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 I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. 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. I agree that a photocopy of this authorization may be considered valid.

_____ _____ _____

Printed Name of Patient/Guardian Signature of Patient/Guardian Date