Colon & Rectal Clinic of Orlando
110 W Underwood St, Ste A, Orlando, FL 32806
FAX: (407) 425-4358 – TEL: (407) 422-3790

COLON AND RECTAL CLINIC OF ORLANDO

HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

RECORDS ON (PATIENT NAME) _____ (DOB) _____

The following specific person or class of persons or facility is authorized to make the requested use or disclosure. If you are sending records to the Colon & Rectal Clinic of Orlando, please put the doctor's name who has your records here:

RECORDS SENT FROM: _____

_____

_____

The following person or class of persons may receive disclosure of protected health information about me. If you are sending records to the Colon & Rectal Clinic of Orlando, please put the doctor's name you are seeing at CRC here:

RECORDS SENT TO: _____

_____

_____

Specific description of information to be released (must include date(s) of service):

_____

The information to be released will be used for the purpose described below:

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
I may revoke or withdraw this authorization by notifying COLON & RECTAL CLINIC OF ORLANDO in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
The authorization will expire on _____, or 1 (one) year after the date of said authorization.

_____	_____	_____
Signature of Individual	Date of Signature	Date of Birth or SS Number

~~OR, if applicable~~

_____	_____	_____
Signature of Guardian	Date of Signature	Description of Guardian's Personal Representative's Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or Person signing on the Individual's behalf.