Colon and Rectal Surgery and The Colonoscopy Center Inc.
AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1) ☐ **Authorization for CRS/CCI Release/Transfer.** The undersigned hereby authorizes Colon and Rectal Surgery Inc. and The Colonoscopy Center Inc. and their employees to use and/or disclose to: _____

_____

For the following purpose(s) (may state "per my request"): _____

_____

The following health information:

- ☐ Entire medical record
- ☐ Entire medical record, excluding:
  - ☐ Health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus)
  - ☐ Health information relating to sexually transmitted diseases
  - ☐ Mental health records
  - ☐ Drug and/or alcohol abuse records
- ☐ Other (specify) _____

2) ☐ **Authorization to Release/Transfer to CRS/CCI.** The undersigned hereby authorizes _____ to release the following health information to Colon and Rectal Surgery Inc. and The Colonoscopy Center Inc. and their employees for the purpose of continuation of my medical/surgical care:

- ☐ Entire medical record
- ☐ Entire medical record, excluding:
  - ☐ Health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus)
  - ☐ Health information relating to sexually transmitted diseases
  - ☐ Mental health records
  - ☐ Drug and/or alcohol abuse records
- ☐ Other (specify) _____

3) **Conditions.** We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

4) **Further Uses and Disclosures.** When we use or disclose your health information as you have instructed us in this authorization, we do not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by Federal and State privacy laws.

5) **Expiration.** This authorization shall expire upon the earlier of _____ or one year from the date of this authorization, except that any authorization to release medical records hereunder shall expire no later than twelve (12) months from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

6) **Revocation.** You have the right to revoke this authorization at any time by providing us with written notice by certified mail or hand delivery to the following address:

Colon and Rectal Surgery Inc., Attention Privacy Officer, 9850 Nicholas Street, Suite 100, Omaha, Nebraska, 68114. FAX: 402-392-6443

When we receive your revocation, we will immediately stop using and disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and discloses we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

_____ _____

PRINTED PATIENT NAME PATIENT ACCOUNT NUMBER (IF KNOWN)

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

***NOTE: IF SIGNED BY SOMEONE OTHER THAN THE PATIENT, WE MUST HAVE WRITTEN PROOF OF HIS/HER AUTHORITY.**