



AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Authorization: The undersigned hereby authorizes Colon and Rectal Surgery Inc. and The Colonoscopy Center Inc. and its employees to use and/or disclose:

for the following purpose(s):

- Further Medical Care Research Insurance Disability Personal Use
 Other (Specify): _____

The information to be disclosed from my health record: (Check appropriate box(es))

- Entire Record
 Only information related to (specify): _____
 Only from the period of events from: _____ to _____
 Other (please specify): _____

Revocation and Expiration: I understand that I may revoke this authorization in writing submitted at any time to Colon and Rectal Surgery Inc., Attn: Privacy Officer, 9850 Nicholas Street, #100, Omaha, NE 68114, Fax: (402) 343-1122. When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date is stated:

Expiration date: _____

Conditions: I understand that my treatment will not be conditioned on my providing this authorization except if such care is provided for research purpose.

Further Uses and Disclosures: I understand when health information is disclosed to other parties as instructed in this authorization, Colon and Rectal Surgery Inc. and The Colonoscopy Center Inc. will not have the ability to monitor whether the health information is further used or disclosed by such parties. In such situations, the disclosed health information may no longer be protected by Federal and State Privacy Laws.

Signature: _____

Printed Name: _____

Date: _____

Employee Initials: _____

Note: If signed by someone other than the patient, we need written proof of your authority.