CSL COLON STOMACH LIVER CENTER

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Authorization of Medical Release of Medical Information

Attention:

Patient's Name: Date of Birth:

I, _____, request and authorize _____ to release the healthcare information of the patient listed above to:

Provider/Facility Name:

Address:

Contact Number: Fax Number:

This request and authorization applies to:

- ☐ Healthcare information related to the following treatment, condition or dates:
  _____
- ☐ All Healthcare Information
- ☐ Other: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for twelve (12) months from the date of the signature. I understand that I may cancel with written notification, but that it will not affect any information released prior to notification of the cancellation. 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 regulations. I understand that the medical provider to whom this authorization is furnished may not condition their treatment of me on whether or not I sign this authorization.

Signature: _____ Date: _____