Colon and Rectal Surgery Associates
Pelvic Floor Center
Riverside Endoscopy Center

Broadway Place East
3433 Broadway Street NE # 115
Minneapolis, MN 55413

Medical Records Phone: 651-312-1553
Medical Records Fax: 651-312-1570

Authorization for Release of Information

PATIENT NAME: _____ DATE OF BIRTH:_____ MAIDEN NAME: _____
ADDRESS: _____CITY: _____ STATE: _____ ZIP CODE: _____
DAY PHONE NUMBER: _____ FAX (if applicable): _____ EMAIL ADDRESS: _____

RELEASE RECORDS **FROM:** **COLON AND RECTAL SURGERY ASSOCIATES**
PELVIC FLOOR CENTER
RIVERSIDE ENDOSCOPY CENTER or ☐ Other: _____

RELEASE RECORDS **TO:** **Person/Clinic/Hospital/Organization Name: _____**
Address:_____
City: _____ State: _____ Zip Code:_____ Email: _____
Phone: _____ Fax: _____ Next MD/Patient Portal: ☐

INFORMATION TO BE RELEASED:

☐ Clinic related (Clinic consults, office visits, lab, pathology, radiology reports)
☐ Hospital (Consult, history & physical, operative, pathology, lab, radiology reports, discharge summary)
☐ **Date range**: _____ ☐ Other _____

☐ Office Visit	☐ Pelvic Floor Testing	☐ Hospital Consult/H&P	☐ Endoscopy/Colonoscopy
☐ Lab Report	☐ Pathology Report	☐ Radiology Report	☐ Discharge Summary
☐ Billing records	☐ Biofeedback	☐ Rectal Ultrasound Note	☐ Operative Report

PURPOSE OF DISCLOSURE: ☐ Changing physicians ☐ Consultation/Second Opinion ☐ School ☐ Insurance
☐ Continuing Care ☐ Worker's Compensation ☐ Personal File ☐ Legal ☐ Other_____

I understand that:

(1) **If no date range is listed above, records released will only include information from the past five years.**
(2) This authorization is effective for one year from the date I sign below.
(3) My medical information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse. **If you would like to opt out, please check this box.** ☐
(4) I can revoke this authorization, in writing, at any time, but my revocation will not apply to any information already released in good faith.
(5) I can send a request for revocation or questions about disclosures to the Medical Records Department at the address listed above;
(6) Once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure.
(7) I can refuse to sign this authorization and still be assured treatment.
(8) I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524
(9) A photocopy/fax of this authorization will be treated in the same manner as the original.

I hereby release the facility, its employees and my physician(s) from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information. Authorizing disclosure of my medical information is voluntary.

* _____ * _____
Signature of Patient/Authorized Representative **Date**

* _____

If the patient is not the authorized signing individual, please note the relationship and provide legal documentation.

OFFICE USE ONLY Completed: _____Completed by: _____

CONTENT: The Privacy Regulation establishes the following requirements for the content of Authorization forms:

- Be in writing
- Be in plain language

Authorization forms must contain at least the following core elements:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion
- The name or other specific identification of the person(s), or class or persons, to whom the provider may make the requested use or disclosure
- A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study, "none," or similar language is sufficient if the authorization is for a use of disclosure of PHI for research, including for the creation and maintenance of a research database or repository
- Signature of the individual
- Date
- If the authorization is signed by a personal representative, a description of such representative's authority to act for the individual

Authorization forms must contain at least the following required statements:

- A statement of the individual's right to revoke the Authorization in writing and either a statement of the exception to the right to revoke or a description of how the individual my revoke the authorization
- A description of how the individual may revoke the Authorization
- A statement that the covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization and a statement that lists the consequences to the individual of a refusal to sign the authorization
- A statement that information disclosed pursuant to the Authorization to be subject to redisclosure by the recipient and no longer protected by this rule
- The signature of the individual
- The date
- If the authorization is signed by a personal representative, a description of their authority to act for the individual

MAINTENANCE: The Privacy regulation establishes the following requirements for the maintenance and distribution of Authorization forms:

- The covered entity must provide the individual with a copy of the signed Authorization when the covered entity seeks an Authorization from an individual for a use or disclosure of PHI
- Signed Authorization forms must be retained for six years from the date of creation or the date they were last in effect, whichever is later

Note: Special rules apply to Authorizations for the use and disclosures of PHI created for research that includes treatment of the individual and Authorizations for the use of disclosure and Psychotherapy Notes.