COLORECTAL SURGICAL ASSOCIATES

Pierre Castera, MD Ben Mizrahi, MD Lina O' Brien, MD Jeremy Cravens, MD Ivane Chua, MD Darcy Shaw, MD
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REQUEST FOR THE DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I,

_____

(Print First, Middle Initial and Last Name , Date of Birth and current telephone number)

Consent to and authorize:

_____

(Print Name of person or facility, address, City, State and Zip and telephone number)

To furnish to Colorectal Surgery Associates, PC, the following medical records and information:

_____

(Reason for release of records)

I understand this authorization may be revoked in writing at any time unless it's already acted upon. To revoke this authorization I must send a request in writing to:
Colorectal Surgery Associates, PC, 4370 W 109th St Suite 350 Overland Park, KS 66211
This authorization expires on:

_____

(Date or Event)

Or within one (1) year of the date signed if I have not provided an expiration date or event.

I authorize the release of my records: (check one)

☐ Only records originated prior to today's date (not including today's date)

☐ Records originated both before and after today's date (including today's date)

☐ Records originated only after today's date (including today's date)

I understand that my information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and would no longer be protected by the Privacy Regulations. A copy of this authorization shall be considered as effective and valid as the original.

Signature of Patient or Authorized Representative. If Authorized Representative, please also include relationship to patient:

_____

Signature Date Relationship to Patient