Colon & Rectal Associates

1811 E. BERT KOUNS, SUITE 430
SHREVEPORT, LA 71105

PHONE: (318) 424-8373
FAX: (318) 424-6477
colonandrectalassociates.com

Leaders and Innovators in Colon and Rectal Surgery

Michael D. Stratton, MD, FACS, FASCRS
Andrew M. Werner, MD, FACS, FASCRS
Brielle R. Hebert, MD

Authorization for the Disclosure of Protected Health Information

As required by the Health Portability and Accountability Act of l996, Colon and Rectal Associates may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for the disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION

I, _____ (print name)
hereby authorize the disclosure of the following that pertains to me:

☐ Complete Medical Record OR: _____

_____

For the following purpose:

_____

I authorize the following persons to make these disclosures of my health information:

_____

I authorize the following persons to receive these disclosures of my health information:

_____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, the following is included in this Disclosure of Protected Health Information authorization.

Alcoholism **Drug Abuse** **Mental Health** **Vocational Rehabilitation** **HIV (AIDS)**
Sexually Transmitted Diseases **Genetics** **Psychotherapy Notes**

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Colon and Rectal Associates. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire one month from the authorization date.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____ _____
Signature Date of Birth Date

REVOCATION SECTION

I hereby revoke this consent.

_____ _____
Signature Date