Designated Party Release

COLON-RECTAL SURGERY ASSOCIATES, PC
410 UNIVERSITY PARKWAY SUITE 2100
AIKEN, SC 29801
803-648-1171

Colon-Rectal Surgery Associates PC has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Colon- Rectal Surgery Associates, PC may update the "Notice of Privacy Practices". If I ask, Colon- Rectal Surgery Associates, PC will provide me with the most current "Notice of Privacy Practices".

You may give **Colon-Rectal Surgery Associates, PC** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient Name: _____ Date of Birth:___/___/_____

Date:___/___/_____ Account #:_____ Chart #:_____

At my request, I authorize **Colon-Rectal Surgery Associates, PC** to disclose my protected health information to:

Name:_____ Phone #:_____

Name:_____ Phone #:_____

Name:_____ Phone #:_____

At my request, I also authorize **Colon-Rectal Surgery Associates, PC** to communicate my protected health information to me via the following methods:

☐ Leave detailed message on my home answering machine (phone #:_____)

☐ Leave detailed message on my voice mail at work (phone #:_____)

☐ Leave detailed message on my cell phone voice mail (phone #:_____)

☐ Fax detailed medical information (fax #:_____)

☐ E-mail detailed medical information (e-mail:_____)

Authorized Signature:_____ Date:_____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **Colon-Rectal Surgery Associates, PC** took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation:_____

Date Authorization Cancelled: ___/___/_____

Form 10DPR Maintain a copy of the Designated Release Form with the administrative documents section of the patients medical record.