Chart #: _____

Date: _____

Colon and Rectal Surgery Associates
MEESE, TOLLAND, RITTER AND WILLIAMS, M.D.,P.A.

550 Memorial Circle, Suite H
Ormond Beach, Florida 32174
(386)672-0017 Fax: (386)676-0506

Certified by: American Board of Surgery
American Board of Colon & Rectal Surgery

9d

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Address: _____

Daytime Phone _____ Date of Birth _____

DATE INFORMATION NEEDED: _____ Mail _____ Pick Up _____

I hereby authorize _____

_____ to disclose to :

_____

(Name of Person/Facility) (Street) (City) (State) (Zip)

The following information: _____

_____

_____

This request may include release of information pertaining to:

(Please initial by each category)

Psychiatric _____ HIV test results _____

Drug/Alcohol _____ Aids related _____

I understand that my records cannot be disclosed without my written consent, unless otherwise provided for under current law.

I also understand that I may revoke this consent at any time except to the extent that action have been taken in release to it and that in any event this automatically expires ninety (90) days from the date signes.

PATIENT SIGNATURE: _____ Date: _____

EMPOWERED REPRESENTATIVE: _____ Date: _____

WITNESS: _____ Date: _____