



Kendrick Regional Center

Surgical expertise you can trust.

KENDRICK REGIONAL CENTER FOR COLON & RECTAL CARE, LLC

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION TO THOSE INVOLVED IN THE PATIENT'S CARE AND FOR NOTIFICATION PURPOSES

Patient's Name:			
	Last	First	Middle Initial
Home Address:			
	City	State	Zip Code
Home Telephone:		Date of Birth:	

I, _____, request that Kendrick Regional Center for Colon & Rectal Care, LLC disclose to the following family members or friends my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. Kendrick Regional Center for Colon & Rectal Care, LLC may also use or disclose this information as necessary to notify the following individuals of my general condition, location or death. Please list any family or friends that would be with you at the time of a procedure, or might call the doctor with any questions-this gives us permission to release any necessary information.. (List name, phone number, and relationship to patient.)

_____ Signature of Patient (or Healthcare Representative)	_____ Date
--	---------------

If patient is unable to sign, but circumstances are such that it can be reasonably inferred that the patient intends to consent to such disclosure, so note by checking and initialing here:
