Medical Record Request

Patient Name: LAST ________________
FIRST______________________

Patient ID:

Patient DOB:

I, _____________hereby authorize COLORECTAL WELLNESS CENTER and its affiliates, its employees and agents to obtain the following medical records from

____

Institution Name phone fax address.

Check all that apply:

______ complete medical record
______ labs and pathology
______radiology reports
______operative reports

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary

______________________________________ ______________________________________

Patient Printed Name Date

____

Patient Signature

If applicable, Legal Representatives sign

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.