Rochester Colon & Rectal Surgeons
600 Red Creek Drive, Ste 200
Rochester, NY 14623
Phone: (585)222-6566 Fax: (585)338-1477

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's name: ______________________________________ Date of Birth: _______________________
Address: ____
City/State/Zip Code: ____
Patients Phone #: ____

This Authorization allows Rochester Colon & Rectal Surgeons to: (Check one)

☐ Send copies of your record to the Provider or facility below:
☐ Receive copies of your record from the Provider or facility below:

____
(Name of Provider) (Address)

____
(City, State, Zip Code) (Phone/ Fax #)

What type of access are you requesting?

☐ RCRS Chart — Upload to your RCRS chart. Download or print this information to a secure location once received in your RCRS chart. Free of charge.

☐ Paper Copy — You should receive notification within 10 days from our release of information of cost of copies.

Please check here ☐ if you need to pick up your records. Charges may still apply. The office will notify you when records are ready to be picked up. RCRS has 7 – 10 days to process your request

Type of records requested: (Check all that apply)

☐ Procedure Reports ☐ Imaging Reports ☐ Pathology Reports ☐ Office Notes
Other: ____
____

To better serve our patients, we would appreciate knowing why you are transferring from our practice:

☐ Not transferring (personal) ☐ Moving ☐ 2nd Opinion ☐ Health Ins Change
Other (please specify): ____

I understand that I may revoke, in writing, this authorization at any time, but revocation will not apply to information that has already been released under this authorization. I understand that if a party authorized to receive the information is not a health provider; the information may no longer be protected by federal privacy regulations. This authorization for release of information expires (check one; specify date or condition, if applicable). I understand my right to healthcare treatment is not conditioned on this authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed. There may be a charge for the requested records. 75 cents per page prior to records release for providing copies of above information will not exceed $50.00

Signature of Patient or Representative ___________________________Date: ______________
Relationship to Patient (if requester is not the patient) __________________________________
Co-Signature of Minor Patient (ages 12-17) ____

Note: *To authorize the disclosure of medical records containing information related to symptoms or treatment of AIDS including test results for the presence of HIV or an antibody to HIV, an additional release form (DOH-2557) will need to be completed.*