



## Information Release Form

Release of Information from Previous Practitioners (sign here)

I give my permission for all my existing medical records and studies to be released to Montgomery Colorectal Surgery LLC for the express purpose of review and to assist in my further medical care.

I understand that this information will be used to help in my own medical treatment and may also be used in an anonymous or conglomerate fashion as part of clinical research activities.

I also am assured that information obtained from outside Montgomery Colorectal Surgery LLC will not be further transferred without my permission or unless directed to do so by an appropriate legal authority.

Authorization to Release Information to Other Individuals (signature)

I hereby give permission to Montgomery Colorectal Surgery to release information to the following individuals. I understand that Montgomery Colorectal Surgery LLC will release and discuss information only with those individuals listed below and by the specified means of communication.

\_\_\_\_\_ by the use of  
Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

\_\_\_\_\_ by the use of  
Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

\_\_\_\_\_ by the use of  
Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

\_\_\_\_\_ by the use of  
Phone \_\_\_\_\_ Email \_\_\_\_\_ Fax \_\_\_\_\_

\_\_\_\_\_  
Signature of the patient or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship if not the patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date