

**Kitsap ColoRectal Surgery, Inc., P.S.**  
**Authorization to Release Health Care Information from KCRS**

Patient's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Sex: \_\_\_\_\_ SSN: \_\_\_\_\_ Previous name (if applicable): \_\_\_\_\_

**Please mail this form to:**            **Kitsap ColoRectal Surgery, Inc PS**  
   **C/O Kathleen Green, MBA**  
   **PO Box 3830**  
   **Silverdale, WA 98383**

This PO Box is checked weekly. Please allow 2 to 3 weeks for us to fulfill records requests.

*If records are needed urgently for medical treatment please have your physician call St Alphonsus Medical Center at 208-367-2121 and ask to speak with Dr Johnny B Green directly.*

Are these records needed for an upcoming appointment with another physician?     YES     NO

My appointment is with Dr. \_\_\_\_\_ on \_\_\_\_ / \_\_\_\_ / \_\_\_\_.

I request and authorize **Kitsap ColoRectal Surgery, Inc, PS** to release health care information of the patient named above to:

**Send Records to:**

(Patient/Clinic/Physician Name) \_\_\_\_\_

(Address) \_\_\_\_\_

(City, ST, Zip) \_\_\_\_\_

(Phone) \_\_\_\_\_ (Fax) \_\_\_\_\_

This request and authorization applies to:

Only health care information relating to the following treatment, condition, or dates of treatment:

\_\_\_\_\_

All health care information

Other: \_\_\_\_\_

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

\_\_\_\_\_  
Signature of patient or patient's authorized representative

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)