Designated Party Release

You may give Colonial Healthcare written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-rays, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient Name: _____ **Date of Birth:** _____/___/_____

Today's Date: ___/____/____ Chart #: _____

At my request, I authorize Colonial Healthcare to disclose my protected health information to:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

At my request, I also authorize Colonial Healthcare to communicate my protected health information to me via the follow methods:

___ Leave detailed message on my home answering machine (phone #: _____)

___ Leave detailed message on my voicemail at work (phone #: _____)

___ Leave detailed message on my cell phone voicemail (phone #: _____)

___ Fax detailed medical information (fax #: _____)

___ E-mail detailed medical information (e-mail: _____)

Authorized Signature: X_____ **Today's Date:** X___

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **NOT** affect any action Colonial Healthcare took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: _____/_____/_____