Primary Care Provider/Clinic Release Form

Authorization for Release of Information from Your Cancer Risk Assessment and Evaluation Session

If you would like us to send your doctor or health care provider summary information from your cancer risk assessment and evaluation session, please provide their contact information below:

Hospital/Clinic Name: _____

Physician Name: _____

Address: _____

City: _____ **State:** ____ **Zip:** _____

Phone #: _____ **Fax #:** _____

I give my authorization to release information regarding the cancer risk assessment and evaluation I received as part of the Family CARE (Colorectal Cancer Awareness & Risk Education) Project to my doctor or health care provider listed above.

Print Name: _____ **Date of birth:** _____

Signature: _____ **Date:** _____

Please return this form to:

NAME
ADDRESS

If you have any questions, please feel free to call the Family CARE Project office at xxx-xxx-xxxx or toll-free at xxx-xxx-xxxx or email us at EMAIL@ADDRESS.