

Participant ID No. _____



**COLORECTAL CANCER EDUCATION, SCREENING AND PREVENTION
PROGRAM (CCESP): EMPOWERING COMMUNITIES FOR LIFE
RELEASE OF INFORMATION**

1.

Patient name _____
Date of Birth _____
Today's Date _____
Phone # _____ Other Phone # _____

I, _____, give my consent to release information
about my colorectal cancer screening test results
(Patient Name)

2.

From: [Insert Organization's Name]
Attn: Colorectal Cancer Education, Screening and Prevention Program

To: Primary Care Doctor _____
Address _____
Phone _____

3.

I also give consent to release information about my colorectal cancer screening test results

From: Endoscopy Facility _____
Address _____
Phone _____

Lab Facility _____
Address _____
Phone _____

To: [Insert Organization's Name]
Attn: Colorectal Cancer Education, Screening and Prevention Program

4. This release will be for one year. I understand that I can take back this release at any time by giving a written notice to [Insert Organization's Name]. A photocopy of this form will be considered valid.

Participant Signature _____ Date & Time _____