MEDICAL RECORDS REQUEST AND AUTHORIZATION TO RELEASE
6-29-2020

I hereby authorize the physician(s), staff or designated agents of:

Practice/Doctor Name: ____

Address: ____
Street Address City State Zip

To release the medical records of ____
Patient Name

Patient Date of Birth ______________________ Patient Social Security Number _____________________

To the physician(s), employees or designated agents of Texas Colon & Rectal Specialists (TCRS) for the following dates of service:

____ to ____

This authorization is to include any items considered Protected Health Information under the Health Insurance Portability Act of 1996. Additionally, TCRS shall comply with all provisions of this act concerning security, privacy and any re-disclosure.

This request is being made for the purpose of diagnosis and possible treatment of this patient.
Released information should include:

___________ H & P, Operative Reports and dictated summaries

__________ Reports of any laboratory, imaging or pathology studies

___________ Any other information appropriate to the accurate assessment of this patient's medical history or health status.

This authorization is valid and binding until:
1) ___________ Requested information is received by TCRS
OR
2) ___________ A period of ________________________________ from the date signed

Requested information should be forwarded to TCRS by mail or fax:
Mail: TCRS, Attn. ________________________________, 16980 Dallas Parkway, Suite 200, Dallas, TX 75248
Fax: Please send with a cover sheet addressed to Medical Records Release Officer at 214-342-3054

Patient authorizes TCRS to send records to: (Please list address or information below)

___

___

Signatures:
Patient/Legal Representative x ____

If Legal Representative, relationship to patient: ____

TCRS Witness x: ____