Denton Colon & Rectal Surgery

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Medical Records Release Form

[ ] Healthcare provider [ ] Family /Friend [ ] Power of Attorney

Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Phone: _____ Fax: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my records, or a summary or narrative of my protected health information.

Patient Name:_____ Date of Birth:_____

Description of the specific information to be released: _____
_____

Release my protected health information to the following person(s)/entity:
_____
_____
_____

Phone ( ) _____- _____ Fax ( ) ____ - _____

The reasons or purposes for this release of information are as follows: _____
_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Permission is requested by patient to: [ ] mail [ ] hand carry [ ] fax

Revocation of your authorization to release medical information must be produced in writing to us.

_____
Patient (or legal representative) Signature Date

_____
Witness Date