TCRS
Colorectal Specialists
Improve Your Outcome

MEDICAL RECORDS REQUEST AND AUTHORIZATION TO RELEASE

R. 1-25-2016

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 DOB Patient SS #

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

_____to _____

This authorization is to include any items considered Protected Health Information under the Health Insurance Portability Act of 1996. Additionally, Texas Colon & Rectal Specialists (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 Texas Colon & Rectal Specialists (TCRS)
or
2. _____ A period of _____ from the date signed

Requested information should be forwarded to Texas Colon & Rectal Specialists by fax or by mail:

If by mail- - TCRS, Attn: _____ , 11551 Forest Central Drive, Suite 133 • Dallas, Texas 75243

If by fax- - Please send with a cover sheet addressed to Medical Records Release Officer and fax to 214.342.3054

Patient authorizes Texas Colon & Rectal Specialists to **send records to**: (Please list address or information below)

_____

_____

SIGNATURE:

Patient/Legal Representative: ✕_____Date: _____

If Legal Representative, relationship to patient:_____

TCRS Witness: ✕_____Date: _____