Authorization to Release Medical Records

Central Texas Colon and Rectal Surgeons

Robert Cline, MD - David Fleeger, MD – April Fox, MD - Ernest Graves III, MD
Thiru Lakshman, MD - John Mangione, MD - William Robertson, MD - Ricardo Solis, MD

Patient Name:	Date of Birth:

I, the person identified above, hereby request and authorize Physicians of Central Texas Colon and Rectal Surgeons (CTCRS) to use or disclose my protected health information (PHI) subject to the following authorization:

RELEASE RECORDS **TO**:

NAME:_____

PHONE NUMBER:_____

ADDRESS:_____

_____

FAX NUMBER:_____

RELEASE RECORDS **FROM**:

NAME:_____

PHONE NUMBER:_____

ADDRESS:_____

_____

FAX NUMBER:_____

The purpose for this disclosure is as follows:_____

The information to be used or disclosed: (Please check all that apply.)

_____My entire record for continuation of care, or specify other reason:_____

_____My demographic information only (Name, age, address, gender, insurance, telephone, etc.)

_____My Medical Data/Information related to:_____

_____Other:_____

This authorization shall remain in force and effect until it expires on this specified date:_____. If I fail to specify a date, specific event or condition, then this authorization will expire in one year.

I understand I have a right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, we must receive a notice in writing.

Central Texas Colon and Rectal Surgeons, Attention: Privacy Officer

4106 Medical Parkway, Austin, TX 78756

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPAA privacy regulations. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon my signing this authorization.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship to Patient (If applicable)