Medical Release of Information Form

I request and authorize that my medical records to be sent via mail or fax to:

North Texas Gastroenterology Associates, PLLC

204 Medical Dr., Ste. 240 Sherman, TX 75092

F: 877-581-1491

Reason for release: Initiation of care/Continuity of care

This request applies to: Colonoscopy report, EGD or ERCP report, CT/(CAT) Scan, Abdominal US/x-ray, office notes, hospital notes, ER discharge notes and pathology/lab reports.

Health care information relating to the following treatment condition or dates of treatment:

All health care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

_____ Excluding the above information regarding HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.

I understand that I have the right to revoke this authorization by providing a written request to do so to the above-named physician or organization. I understand that the revocation will not apply to information that has already been released.

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.) Unless otherwise revoked of this authorization will expire 12 months from the date signed. I understand that authorizing the disclosure of this health information is voluntary and that it carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

Patient/authorized representative signature: _____

Patient Printed Name: _____ Date of birth: _____ Date: _____