TEXAS★ENDOSCOPY

Medical Record Release Authorization

(Legal Identification is required for any below information to be released)

I hereby authorize:

☐ **Texas Endoscopy- Independence Medical Village**
8080 Independence Parkway, Suite 160
Plano, Texas 75025

☐ **Texas Endoscopy**
6405 West Parker Road, Suite 370
Plano, Texas 75093

Billing Information:

☐ Explanation of Benefits ☐ Detailed Receipt ☐ Billing Consent Forms

Medical Record Information:

☐ Op Report ☐ Pathology Report ☐ Consent Forms ☐ Entire Record

To release the following medical records via:

☐ Mail ☐ Email ☐ Fax ☐ Patient came to facility

To: _____

_____

_____

Patient: _____ DOB: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____

Witness: _____

Notice to Recipient of Patient Records:
The recipient of this information is prohibited from disclosing the information to any other party and is required to destroy the information after the stated need has been fulfilled.