TEXAS★ENDOSCOPY

Medical Record Release Authorization

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

I hereby authorize:

Texas Endoscopy- East
8080 Independence Pkwy, #160
Plano, Texas 75025
(972) 908-3000

Texas Endoscopy- West
6405 W. Parker Rd, #370
Plano, TX 75093
(972) 473-9900

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

Please fax completed form to (972)908-3066.

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.