# 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 ☐ Consent Forms

**To release the following medical records via:**

☐ Mail ☐ Email ☐ Fax ☐ Patient came to facility

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To: _____

_____

_____

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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.