Fax to: 682-236-0038
Mail to: Texas Health Phys. Group Release of Information
500 E. Borde Street, Suite 700
Arlington, TX 76010
Questions about this form, call: 800-947-8943

Medical Release of Information Form

Patient Name:_____ Date of Birth:_____

Social Security #:_____ Previous Name:_____

Home Phone:_____ Other Phone: _____

Address, City, State, Zip_____ Fax_____

I request and authorize Dr. Raymond Staniunas, Texas Health Physicians Group
(Name of Physician and Clinic/Practice records are requested from)

To release the medical record of the above named patient to:

Name of recipient: Dr. Raymond Staniunas, Colon and Rectal Associates of Texas

Address: 1705 Ohio Drive, Suite 100

City & State: Plano, TX Zip Code: 75093

Phone Number: (972) 612 - 0430 voice (972) 612 - 0529 fax

Reason for release: Continuity of Care

This request and authorization applies to: (initial appropriate line)

____Health Care information relating to the following treatment condition or dates of treatment:

_____

This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

____All Health Care information **including** information relating to HIV/AIDS testing sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____All Health Care Information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____ I understand 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.

_____ _____ _____
Signature of Patient or Legal Representative Date

_____ _____
Representatives Relationship to Patient Representatives Printed Name

_____
Patient or Representatives Phone Number

Unless otherwise revoked this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.