Colon & Rectal Associates of Texas
1705 Ohio Drive – Suite 100 – Plano, Texas 75093
972.612.0430/Fax 844.585.6193
☐ **Said Hashemipour, M.D.** ☐ **Todd A. Odom, M.D.** ☐ **Salim Jabbour, M.D.** ☐ **Julie K. Leverton, M.D**

Authorization to Release Healthcare Information

Patient Name _____Date of Birth: _____

I request and authorize _____ to release healthcare information for the above named patient to:

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This request applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information

☐ Other: _____

***Definition**: Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq., includes, but is not limited to, herpes, herpes simplex, human papilloma virus, wart, genital warts, condyloma, syphilis, gonorrhea, HIV and AIDS*

☐ Yes ☐ No I authorize the release the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give written permission before disclosure of these test results to anyone.

Patient/Guardian Signature _____ **Date**_____

THIS AUTHORIZATION EXPIRES NINETY(90) DAYS AFTER IT IS SIGNED

Please be advised that our office charges a reasonable fee for copying and sending medical records according to guidelines adopted by the Texas State Board of Medical Examiners. This fee is $25.00 for the first twenty (20) pages of records and $.50 for each additional page. The fee must be paid prior to our office sending out your records. Please provide your phone number(s) below so our Medical Records Clerk can notify you of the exact fee for your records. Thank you.
Note: the fee does NOT apply when sending records to another physician's office.

Main contact phone number _____ Secondary contact number _____

You may charge your fee for records to your credit card. If you enter the information below, you will not be charged until our office contacts you for the amount and permission to charge. *If you have any questions about fees, please contact Medical Records at 214.501.1110.*

Card No.: _____
Exp. Date: _____
Signature: _____
Print Name: _____

Note: there are no fees when sending to another physician.

Fax to: 844.585.6193

FOR OFFICE USE ONLY

FEE AMOUNT: $_____
Company/person contacted and approved fee
Date:_____

Employee initials: _____

Notes:
_____
_____
_____