



### Medical Release of Information Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Previous Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Address, City, State, Zip \_\_\_\_\_

I request and authorize: \_\_\_\_\_  
(Name and Address of Physician and/or Clinic/Practice you want to release your records)

Address: \_\_\_\_\_

City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

#### Metroplex Colon & Rectal Specialist

Raymond Staniunas, M.D.,FACS  
2100 Hedgcoxe Road, Suite 120  
Plano, Texas 75025

Phone: 855-273-2825 (855-2RE-CTAL) Fax: 817-701-0575

Reason for release (required field): \_\_\_\_\_

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.*

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

\_\_\_\_\_ 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)

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. Treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

I understand I have the right to revoke this authorization by providing a written request to the above named physician or organization. I understand that the revocation will not apply to information that has already been released in good faith. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility on whether I sign the authorization.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

**Unless otherwise revoked this Authorization will expire six months from the date signed or the following designated event:** \_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary.