AMARILLO COLON AND RECTAL CLINIC
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ who resides at, _____ in the city of, _____, in the state of _____, Hereby authorize:

From: Dr./Clinic Name: _____
Address: _____
City, State, Zip: _____

to disclose the following specific medical information by _____ Mail or _____ Fax or _____ Email

To: Dr./Clinic Name: _____
Address: _____
City, State, Zip: _____

from the health records of:
Patients Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
For the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____Records of visits for a specific date or dates.
Specific dates include or are limited to:
_____
_____ Copies of records or reports provided to the above named (i.e. hospitals, lab, clinic, etc.)
_____ Photographs, videotapes, digital or other images
_____ All of the above
_____ Other (must be specific) _____
_____ Mental Health and/or alcohol and drug abuse treatment
_____ AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immune Deficiency Virus) info
_____ Hepatitis Information

_____ Records of visits (all visits)
_____ Progress notes
_____ Discharge Summary
_____ History and Physical Examination
_____ Consultation Reports
_____ Statements of charges or payments

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.
4. Sambasiva R. Marupudi, M.D. / Izi Obokhare, M.D., his employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Patients Name Printed Date

_____ _____
Patients Name Signed Revocation Date
(if other than 60 days from above)

_____
Social Security # (for identification purposes only)

_____ _____
Witness Date