

COLORECTAL SURGERY SERVICES, PLLC HEMORROID INSTITUTE OF SOUTH TEXAS

19288 Stone Oak Parkway, Suite A
San Antonio, TX 78258
Office: (210) 490 - 2828 Fascimile: (210) 490 - 0505

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:

Date of Birth:

Previous Name:

Social Security #:

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: John H. Winston, III, M.D., M.B.A. / Colorectal Surgery Services, PLLC
Wm. Cannon Lewis, M.D. / Colorectal Surgery Services, PLLC

Address: 19288 Stone Oak Pkwy Ste A

City: San Antonio State: TX Zip Code: 78258

This request and authorization applies to:

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

All healthcare information

Colonoscopy report (s). Dates: _____

Pathology report(s). Dates: _____

Office visit notes(s). Dates: _____

Other: _____

Patient Signature: _____ **Date:** _____
