COLORECTAL SURGERY SERVICES, PLLC
HEMORHOID 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:** _____