Office of Gaurav Arora, MD, MS, AGAF
Board Certified in Gastroenterology
Fellowship Trained in Hepatology
2900 North Interstate 35, #210
Denton, TX 76201

Medical Release of Information

Patient Name: ____ DOB: _______________________

Home Phone: ________________________________ Mobile:______________________________

Address, City, State, Zip: ____

I request and authorize ____
(Name of Clinician and Clinic/Practice you want to release your records from)

To Release the medical record of the above named patient to (t*he place you want your medical records to be sent):*
Name of Recipient: Texas Digestive Care, PLLC
Address: 2900 North Interstate 35, #210 Denton, TX 76201
Phone: 940-323-3440
Fax: 940-323-3441

Reason for Release : ____

Requested Information or Dates of Services for Health Care Information Release

- ☐ All Medical Records
- ☐ Medical Records from: _______________ to _____________
- ☐ Procedure / Operative Reports from ____________________
- ☐ Imaging Results from____________________
- ☐ Lab Results from _______________________
- ☐ Clearances for ________________________
- ☐ Other: ________________________________

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand I have the right to revoke this authorization of the release 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.
I understand that this form is for medical records requests and if Texas Digestive Care, PLLC does not get information faxed to them after the *third* attempt, it is my responsibility as a patient to obtain the requested information and provide it to Texas Digestive Care, PLLC for best continuity of care.

____ _________________________________
Signature of patient or authorized representative Date

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