REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Person Requesting records and relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the following individual or organization to disclose my health information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be disclosed to: **North Houston Rheumatology Associates**

Dr. Rama Palwai, M.D. Dr. Prashanth Palwai, M.D.

19701 Kingwood Dr. Bldg #4 Ste A

Kingwood, TX 77339

Fax#: 281-319-4702

425 Holderrieth Blvd #108

Tomball, TX 77375

Fax#: 832-698-2236

920 Medical Plaza Dr. #350

The Woodlands, TX 77380

Fax#: 281-719-8671

For purpose of: **Evaluation and Treatment**

Please release the following:

Radiology Reports Lab Reports

Progress Notes (Last 2 Only) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrativeof my protected health information to the person(s) or entity listed above.

Yes, I consent to release this information No, I do not consent to release this information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Representative Date