

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.

920 Medical Plaza Dr. #350
The Woodlands, TX 77380
Fax#: 281-719-8671

425 Holderrieth Blvd #108
Tomball, TX 77375
Fax#: 832-698-2236

19701 Kingwood Dr. Bldg #4 Ste A
Kingwood, TX 77339
Fax#: 281-319-4702

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 narrative of 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