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 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