AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____

Patient's Full Name Telephone Number

_____

Patient's Address Birthdate

This authorizes: Katy Rheumatology & Associates
19770 Kingsland Blvd, Suite 305
Houston, TX 77094
Tel: 281-578-7438 Fax: 281-578-7450

To release to: _____

_____

_____

NAME, ADDRESS, TELEPHONE AND FAX NUMBER OF FACILITY TO RECEIVE INFORMATION

The purpose of this disclosure is for Continuing Medical care. This authorization is valid for 90 days from the date of signature by the participant.

This authorization applies to all the reports checked:

_____History and Physical _____Progress Note _____Lab Work
_____X-ray & MRI reports _____Other: (specify)_____

I authorize the release of photocopies of the specified medical records, INCLUDING THOSE WHICH MAY CONTAIN INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, OR PSYCHIATRIC DIAGNOSIS/TREATMENT, OR HIV/AIDS TESTING/TREATMENT, OR CONFIDENTIAL COMMUNICABLE DISEASE unless otherwise here in writing: _____, the information may be used by the specified person or organization.

I understand that I may revoke this authorization at any time upon written notice to the above health facility, except to the extent that action based on this authorization has already been taken.

I understand that there is no charge when records are sent directly to a medical provider for continuing care. I also understand that there is a charge when records are mailed to any party other than a medical provider, including when given to me.

Release to myself as Patient/Parent/Legal Guardian of patient
*Administration Fee **$30.00**

PLEASE ALLOW 7-10 BUSINESS DAYS FOR COMPLETION.

Office Use Only:
*Date Completed*_____
Initials _____

_____ _____
LEGALLY AUTHORIZED REPRESENTATIVE (PRINT) DATE

_____ _____
LEGALLY AUTHORIZED REPRESENTATIVE (SIGNATURE) RELATIONSHIP TO PATIENT