

**MEDICAL RECORDS REQUEST**

**I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**Person (s) or Organization (s) authorized to provide the information:**

**Release Records:** Complete Care Physicians, Dr. Shruja Patel  
**TO**  25314 Kingsland  
**FROM** \_\_\_\_\_ Katy, Texas 77494  
O: (832) 508-6632 F: (832) 437-1640

**Release Records:** Name / Facility \_\_\_\_\_  
Address: \_\_\_\_\_  
**TO** \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
**FROM** \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

- A. Records being sent to Complete Care Physicians MUST be FAXED due to our EMR**
- B. This information is to include: COMPLETE MEDICAL RECORDS OR**
- C. These records are to be used for continued medical treatment.**

I understand that this authorization will expire one year from the date signed unless noted.

- 1) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in **A** (above) in writing.
- 2) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.
- 3) I may inspect or copy any information used or disclosed under this agreement.
- 4) I understand that if person or organization that receives the information is not a health care provider or plan covered by Federal Privacy Regulations, the information described above may be redisclosed and would no longer be protected by these regulations:

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Patient's Signature or Patient's Representative

Date

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Printed Name of Patient or Representative

Relationship to Patient