Request for release of Medical Records

I,

Patient Name (please print)

Address *City* *State* *Zip*

Date of Birth *Social Security Number* *Phone Number*

I hereby authorize release of my medical records by:

Name

Address *City* *State* *Zip*

Phone number *Fax Number*

To:

Houston Family Physicians PA

8313 Southwest Freeway Suite 105 Houston Texas 77074 Fax: 832-369-7355	8968 Kirby Drive Houston Texas 77054 Fax: 713-391-8413

Reasons records are being requested for:

- □ Insurance claim
- □ Disability
- □ Review by attorney
- □ Continuing care
- □ Care by physician
- □ Other (Please specify:

Person (or Legal Guardian) Signature *Date*

Witness Signature *Date*