MEDICAL RECORDS REQUEST

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

Patient Name _____ DOB _____PHONE_____

ADDRESS_____ CITY_____ ST_____ ZIP_____

A. **Person (s) or Organization (s) authorized to provider the information:**

Release Records: **Complete Care Physicians, Dr. Shruja Patel**
TO _X__ **633 E. Fernhurst Dr Suite 802**
FROM ____ **Katy, Texas 77450**
O: (832) 508-6632 F: (832) 437-1640

Release Records: **Name / Facility _____**
Address:_____
TO _____ **City_____ ST _____ Zip_____**
FROM _____ **Phone_____ Fax _____**

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

1) I understand that this authorization will expire one year from the date signed unless noted.
2) 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.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.
4) I may inspect or copy any information used or disclosed under this agreement.
5) 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:

Patient's Signature or Patient's Representative Date

Printed Name of Patient or Representative Relationship to Patient