SOUTH HOUSTON INTERNAL MEDICINE, LLC

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REQUEST FOR MEDICAL RECORDS

Re: Patient's Name: _____

Date of Birth: _____

- **MUST PROVIDE INFORMATION BELOW**

Requesting from: _____

Address: _____

Phone #: _____

Fax #: _____

Please Send: _____ **Office Notes**

_____ **Labs**

_____ **X-rays, MRIs, CTs**

_____ **Pathology Reports**

_____ **All Records**

_____ **Other:** _____

_____

I hereby authorize the release of all medical and surgical records. This information is to include, but not limited to, medical information, mental health information, personal habits, alcohol use, drug use, and HIV (AIDS) status, if available.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Patient's Signature: _____ **Date:** _____

Relationship to patient*(if other than self)*: _____

Witness: _____