INCOMING REQUEST FOR MEDICAL RECORDS

TO: _____

Physician Name/Medical Facility Phone Number

_____

Address

_____

City, State, Zip Code

I hereby authorize the release of all my medical records to include any progress notes, test results, lab reports, radiology reports, diagnostic reports, and HIV results in your possession regarding my health, illness and/or treatment.

For the period indicated:

- ☐ Recent
- ☐ Past 12 months
- ☐ All available records
- ☐ From _____ to _____

Please send to : A. Y. Shukla, M. D.

- ☐ 1601 Main Street, Ste.201
  Richmond, Texas 77469
  Phone: 281-341-1500
  Fax: 281-341-1505
- ☐ 16605 Southwest Freeway, Ste.210
  Sugar Land, Texas 77479
  Phone: 281-565-8005
  Fax: 281-242-3518

I release you, your physicians, and employees from liability for following this authorization and request.

AUTHORIZATION IS VALID FOR 90DAYS FROM DATE OF SIGNATURE.

_____

Patient Name(Please Print) Date of Birth

_____ _____

Patient/Legal Guardian Signature Witness

_____ _____

Date Date