



RHEUMATOLOGY PARTNERS OF
HOUSTON, LLC

129 Vision Park Blvd., Ste. 206, Shenandoah, TX 77384
4747 Bellaire Blvd., Ste. 150, Bellaire, TX 77401
O: 281-315-8130 F: 281-315-8131 & 281-315-8132

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Contact: _____

I hereby authorize _____ to release the following information from my health record covering the period from/to _____, if I do not specify a period, I am authorizing the release of records for the entire duration of care with the provider. (**check all boxes that apply below**).

Provider Name, Address, Phone and Fax number:

Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical records). If this box is checked, do not check any additional boxes.			
Progress/Office Visit Notes	Radiology/Imaging Reports	Chemo/Infusion Records	
Lab Reports	Pathology Reports	Billing/Payment Records	
Other:			

Information is to be released to: **Rheumatology Partners of Houston, LLC**

Office # 281-315-8130

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Bellaire, TX 77401
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Dr. Carmen Perez-Masuelli

Dr. Kalpita Hatti

Dr. Leslie Wilson

The information being released for the following purposes:

Continued Treatment	Disability	Attorney/Litigation	Other
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I understand that this authorization will remain in effect until I revoke it in writing. I understand that according to applicable state and/or Federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

Print Patient/Legal Representative Name

Signature of Patient/Legal Representative

Date

REVOKE/CANCEL THIS AUTHORIZATION

Signature of Patient/Legal Representative

Date