REQUEST FOR RECORDS RELEASE

RCH
Rheumatology Clinic of Houston, P.A.
Qaiser Rehman, MD, FACP

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Houston, TX 77065
832.237.8585 Office – 877.672.0442 Fax

Date:

Dear Doctor: _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: _____

Birthdate: _____ Social Security Number: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file pertaining to the following records:

□ Progress notes
□ X-rays
□ Labs/Pathology
□ All records

Thank you for expediting this request. Please send these records to our office address show above.

_____

I hereby authorize the release of all necessary medical records to _____. I wish for them to be forwarded as soon as possible.

Patient's Signature: _____ Date: _____
(or parent if patient is a minor)

Patient's Address: _____ City: _____ State: ____ ZIP Code: _____

Signature of Witness: _____