19255 Park Row, Suite-104
Houston, TX 77084
Phone: (281) 945-5190
New fax update**Fax 281 945 5190**
info@katystomachdr.com

MEDICAL RECORD RELEASE AUTHORIZATION

DATE: ________________

☐ **I am requesting my records from Dr. James Maher's office. (Fill out section 1 and 3)**

☐ **I am requesting my records be sent to Dr. James Maher's office. (Fill out section 2 and 3)**

SECTION 1:

I am requesting Dr. Maher's office to send my records to:

☐ Self: ________________________________ (Please print your name)
**I understand that there will be a fee of $25 for the first 20 pages and .50 for any extra pages.

☐ Another Physician: ____________________________ Fax #: ___________________
Address: ____________________________ Phone #: ___________________
____

**I understand that being faxed to another Physician there is no fee.

SECTION 2:

The patient above has asked Dr. Maher's office to request his/her medical records be released and forwarded to Dr. James Maher's office to the above address. This request is to fully evaluate his/her health to make more informed decisions.

Patient Name: ____________________________ D.O.B.____________________________
Phone #: ____________________________

SECTION 3:

This authorizes you to provide a copy, summary, or narrative of my medical records. As indicated by the checkmark(s) below, or release of confidential information,

☐ Labs, Radiology, Diagnostics testing, Procedure Results, etc.…
☐ H&P, Progress Notes, etc.…
☐ Other: ___________________________________

I hereby authorize the release of all my medical records to be forwarded as soon as possible. I understand and agree to pay the fee per the medical records policy that I signed in my patient paperwork.

Patient: _________________________ Date: ______________________
(Signature)