

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____

Date of Birth: _____

I request and authorize the following practice:

Dr. Radha Tamerisa
 Katy Integrative Gastroenterology
 25230 Kingsland Blvd, Ste 102
 Katy, TX 77494
 Phone: 281-869-3009

To release the patient's medical records requested below to:

Name of Hospital/Provider: _____

Phone Number: _____

Fax Number: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/ or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/ mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

This request and authorization applies to the release of records indicated below.

<input type="checkbox"/> Consult Notes	<input type="checkbox"/> Operative Notes	<input type="checkbox"/> ER Records	<input type="checkbox"/> Colonoscopy Report	<input type="checkbox"/> EGD Report	<input type="checkbox"/> Pathology Results
<input type="checkbox"/> Labs	<input type="checkbox"/> CT Results	<input type="checkbox"/> Ultrasound Results	<input type="checkbox"/> MRI Results	<input type="checkbox"/> Pill Cam	<input type="checkbox"/> All Records Continuation of Care
<input type="checkbox"/> Other:					
Note to office:					

Print Patient Name: _____

Signature of Patient or Representative: _____

If Representative, Name and Relationship to patient: _____

Date: _____