REQUEST FOR MEDICAL RECORDS

Patient Name: **DOB:**

Patient Address:

Requesting Records From:

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Please send the following requested records to:

Provider: ____________________________

☐ Mailed to: 8850 Six Pines Drive, Suite 290
The Woodlands, TX 77380

☐Faxed: 281-364-8833

☐ Pathology Report
☐ Medical History
☐ Exam Notes
☐ All Records
Other: ____

I authorize the transference of the above stated medical records. I also understand and agree that I am financially responsible for all fees, if any, associated with my request, including copying charges, supplies, postage, labor, etc.

________________________________ ____________
Signature of Patient/Legal Guardian Date

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Printed Name of Patient/Legal Guardian