TEXAS HEART & VEIN MULTISPECIALTY GROUP
HOUSTON CARDIOTHORACIC AND VEIN SURGEONS

JON-CECIL WALKES, M.D. | BOMI MAGNUS LAWSON, M.D.
NATHANIEL ALABI, D.P.M. | PARTH DIXIT, D.P.M.

1315 ST JOSEPH PARKWAY SUITE 1704, 10TH FLOOR, HOUSTON TX 77002
1900 NORTH LOOP WEST SUITE 180, 1ST FLOOR, HOUSTON TX 77018
215 KINGWOOD EXECUTIVE DR SUITE 100, KINGWOOD TX 770339
10905 MEMORIAL HERMANN DR SUITE 203, PEARLAND TX 77584

MEDICAL RECORD RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician, person, facility, or entity listed below.

PATIENT NAME: _____DATE OF BIRTH_____

The information you may release subject to this signed release form is as follows:

[ ] Complete Records	[ ] History & Physical	[ ] Progress Notes
[ ] Care Plan	[ ] Lab Reports	[ ] Radiology Reports
[ ] Pathology Reports	[ ] Treatment Record	[ ] Operative Report
[ ] Hospital Reports	[ ] Medication Record	[ ] Other (please specify)

Release my protected health information to the following physician, person, facility, entity, and/or those directly associated in my medical care:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

The purpose or reason for this release of information is as follows:

_____

_____

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Signature

_____	_____
Patient Name	Signature of Patient or Personal Representative
_____	_____
Patient Date of Birth or Social Security #	Printed Name of Patient or Representative
_____	_____
Date	Description of Personal Representative's Authority