**Houston Arthritis and Rheumatology specialists**

# AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

I authorize the transfer of my healthcare information

**from:**

Dr. ______________________________

Clinic/
Hospital: ______________________________

Address: ______________________________

______________________________

Phone: ______________________________

Fax: ______________________________

**To:** Dr. Kiran Farheen, M.D.

23920 katy freeway, st 240

Katy, Texas 77494

Phone: 346-257-4299

Fax: 1-877-764-7610

Health Information Requested:

- ☐ Complete Medical Records
- ☐ Last Consultation Reports
- ☐ Discharge Summary
- ☐ IMMUNIZATION RECORD
- ☐ Hospital Records
- ☐ Imaging Reports
- ☐ Laboratory Reports
- ☐ Other (specify) ______________________________

Reason for Disclosure: ☐ Continuing patient care ☐ Other: ______________________________

Limit Records to: ______________________________

I understand that the specific information to be released may include but not limited to management of drug or alcohol abuse, mental/psychiatric illness or communicable disease. I understand this consent may be revoked at anytime in writing.

*THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE.*

→ ______________________________

**Last Name** **First Name** **Middle Initial** **Date of Birth**

______________________________ ______________________________

Previous Names **Social Security**

→ ______________________________

**Signature** **Date**

______________________________

Signature of Patient Representative Relationship to patient Date