Medical Records Release Form

By signing this form, I authorize the Dr. and legal representative of medical records named below to release my confidential health information about me by releasing a copy of my medical records, or narrative of my protected health information to the entity named below

Release records from :

_____

_____

Patient Name and DOB:

_____

Limitations on the information you may release subject to this Release Form are as follows:

NONE

Physician: Prime Internal Medicine Associates Ph. 972-239-5445, fax **469-729-6691**

Dr Della Mathew / Dr Shalini Katikaneni

Street: 12200 Park Central Drive, Suite 189

City: Dallas, Texas 75251

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

CONTINUTITY OF CARE

Patient signature (or parent, guardian or legal representative)

_____

Date:_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

PLEASE SEND THE FOLLOWING:

Last 4 encounters/office visit notes
Recent lab report within last 12mo
Any radiology reports within last 24mo including colonoscopy, mammogram, EKG, ECHO
Medication List

OTHER:

_____

_____

_____