Katy Medical & Wellness
Methodist West Houston, MOB 1
18400 Katy Freeway, Suite 590
Houston, Texas 77094
Phone (281) 492-1900
Fax (281) 492-1060

Authorization for Release of Medical Records & Information

I authorize and the request the release all my medical information/records (including, but not limited to, information on psychiatric conditions, medical illness', alcohol and drug abuse, and HIV or communicable diseases) to Katy Medical & Wellness for my continued medical care. Please provide the following patient medical records:

_____Please provide labs/diagnostics for the last _____years.
_____Please provide consult notes/specialist notes for the last _____years.
_____Please provide Stress Test/ECHO/Carotids US/ABI
_____Please provide immunization records
_____Please provide EGD/Colonoscopy/US/CT results.

Please send all medical records on my behalf to:

Katy Medical & Wellness
Methodist West Houston, MOB #1
18400 Katy Freeway, Suite 590
Houston, Texas 77094

Phone: (281) 492-1900
Fax: (281) 492-1060
Email: katymedical1@gmail.com

I agree that these provisions will remain in effect until I provide written revocation to Katy Medical & Wellness.

Medical Records to be Released By: _____

Address: _____

Phone/Fax: _____

Patient Name and DOB: _____

Signature of Patient/Legal Guardian: _____

Date: _____