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MEDICAL RECORD RELEASE AUTHORIZATION

DATE: _____

- I am requesting my records from Dr. James Maher's office. (Fill out section 1 and 3)
- I am requesting my records be sent to Dr. James Maher's office. (Fill out section 2 and 3)

SECTION 1:

I am requesting Dr. Maher's office to send my records to:

- Self: _____ (Please print your name)
**I understand that there will be a fee of \$25 for the first 20 pages and .50 for any extra pages.
- Another Physician: _____ Fax #: _____
Address: _____ Phone #: _____

**I understand that being faxed to another Physician there is no fee.

SECTION 2:

The patient above has asked Dr. Maher's office to request his/her medical records be released and forwarded to Dr. James Maher's office to the above address. This request is to fully evaluate his/her health to make more informed decisions.

Patient Name: _____ D.O.B. _____
Phone #: _____

SECTION 3:

This authorizes you to provide a copy, summary, or narrative of my medical records. As indicated by the checkmark(s) below, or release of confidential information,

- Labs, Radiology, Diagnostics testing, Procedure Results, etc....
- H&P, Progress Notes, etc....
- Other: _____

I hereby authorize the release of all my medical records to be forwarded as soon as possible. I understand and agree to pay the fee per the medical records policy that I signed in my patient paperwork.

Patient: _____
(Signature)

Date: _____