# *Houston Female Urology*][**MEDICAL RECORDS RELEASE FORM**

☐ **TO** ☐ **FROM**

Physician _____

Facility _____

Address _____

City, State Zip _____

Fax Number _____

Phone Number _____

☐ **TO** ☐ **FROM**

Dr. Christina Pramudji
Houston Female Urology, PA
18400 Katy Freeway, Suite 530
Houston, Texas 77094
(281) 717-4003
fax (281) 206-7597

**Patient Name:** _____ **Date of Birth:**_____

**Home Address:**_____

**Phone Number:**_____

**Information requested**: ☐ All Medical Records ☐ Laboratory Reports ☐ Radiology
Other: _____

**Purpose of Disclosure: (Please select only one box)**
☐ Treatment/Continuing Medical Care
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other _____

**To be completed only for third-party disclosures. (If the disclosure is for personal use, skip this section.)**
I want the requested medical records to be sent to the third-party (for example, an employer or a school) I have indicated below. My completion of this form serves as authorization for Houston Female Urology to disclose these records to this person or group. I understand that once my information leaves Houston Female Urology, Houston Female Urology is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Name:_____Phone_____

Mailing
Address:_____

**Terms of Authorization**: I understand that fees may apply. I also understand this authorization may be revoked in writing at any time, according to the instructions in Houston Female Urology Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for psychotherapy notes. Houston Female Urology will not condition treatment or payment on my completion of this form.

Signature:_____Date: _____

Printed name:_____Relationship to patient: _____