Fort Bend Rheumatology Associates

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**Authorization to Release Healthcare Information**

**Patient's Name:** ____________________________________________________ **Date of Birth:** ________________

I request and authorize **Fort Bend Rheumatology Associates** (P: 281-980-1742 F: 281-980-1754)

To release healthcare information of the patient named above to:

______________________________________________________________________________

**Phone:** _________________________ **Fax:** ___________________________

**This request and authorization applies to:**

☐ All Healthcare Information

☐ Healthcare information relating to the following treatment, conditions, or dates:

______________________________________________________________________________

☐ The specific records listed below:

______________________________________________________________________________

**The purpose of this request is:**

☐ Transfer of care

☐ For medical treatment

☐ Other: ______________________________________________________________________

**Patient Signature:** ______________________________________________________________

**Date signed:** ________________________

This request expires one year from the date of signature.