Fort Bend Rheumatology Associates

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## Authorization to Release Healthcare Information

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

**I request and authorize:** _____

To release healthcare information of the patient named above to:

Fort Bend Rheumatology Associates
7616 Branford Place, Suite 320
Sugar Land, Texas 77479
Phone: 281-980-1742 Fax: 281-980-1754

**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.