KATY INTEGRATIVE GASTROENTEROLOGY

25230 Kingsland Blvd Ste. 102
Katy, TX 77494
P:281-869-3009
F: (832)-437-5182

AUTHORIZATION TO OBTAIN HEALTH CARE INFORMATION

Patient's Name: _____
Date of Birth: _____

I request and authorize the following practice:

Name of Hospital/Provider: _____
Phone Number: _____
Fax Number: _____

To release the patient's medical records requested below to:

Dr. Radha Tamerisa
Katy Integrative Gastroenterology
25230 Kingsland Blvd, Ste 102
Katy, TX 77494
Phone: 281-869-3009

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/ or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/ mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

This request and authorization applies to the release of records indicated below.

Please fax records to 832-437-5182

□ **Consult Notes**	□ **Operative Notes**	□ **ER Records**	□ **Colonoscopy** Report	□ **EGD Report**	□ **Pathology** Results
□ **Labs**	□ **CT Results**	□ **Ultrasound** Results	□ **MRI Results**	□ **Pill Cam**	□ **All Records** **Continuation of Care**
□ **Other:**					
Note to office:					

Print Patient Name: _____

Signature of Patient or Representative: _____ _____

Date

If Representative, Name and Relationship to patient:_____