ST. LUKE'S MEDICAL CLINIC
6363 San Felipe, Suite 150
Houston, Texas 77057
Phone: 713-972-8900 Fax: 888-876-4946

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: ____
(Doctor or Hospital)

____
(Address)

PHONE: ____________________ FAX: ____________________

You are hereby authorized and requested to release to:

ST. LUKE'S MEDICAL CLINIC

Dr. ______________________________________

6363 San Felipe, Suite 150
Houston, Texas 77057

the following sections of medical records on:

PATIENT: ____

DOB: ____________________ SSN: ____________________

______ All
______ History and Physical
______ Discharge Summary
______ Operative/Pathology Report
______ Consultation
______ Laboratory Reports
______ Radiology Reports
______ Other, please specify ______________________________________

I understand any of the above requested information may include results of HIV test, if one was performed.

______________________________________ is hereby released from legal responsibility for release of the records indicated and authorized herein.

______________________________________ ____________________
Signature of Patient Date
(or guardian if patient is a minor or unable to sign)

5/2010