

ST. LUKE'S MEDICAL CLINIC
6624 Fannin St., Suite 1240
Houston, Texas 77030
Phone: 832-355-5575 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. _____

6624 FANNIN ST., SUITE 1240
HOUSTON, TEXAS 77030

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
(or guardian if patient is a minor or unable to sign)

Date