Louetta Foot and Ankle Specialists, P.A

Brad Bachmann, DPM Amy Walsh, DPM Vorice Batts, DPM
Spring Location: 8681 Louetta Rd., Ste. 150, Spring, TX 77379 Ph: 281.370.0648 Fax: 281.251.3350
Tomball Location: 455 School St., Bldg 1, Ste. 12, Tomball, TX 77375 Ph: 281.351.5599 Fax: 281.516.9386

REQUEST FOR MEDICAL RECORDS

Patient Name: _____ **Patient D.O.B:** _____ **Phone**:_____

I hereby request that my medical records be released *FROM* Louetta Foot and Ankle Specialists, P.A. (any and all physicians).

I am requesting records for the following period of treatment:

First treatment date: _____ Last treatment date: _____

OR(circle): Any and all service dates on file

Please release records *TO* (recipient name): _____

The requested records are for the purpose of (circle one):

Continuing care Personal Copy Insurance Disability Other _____

Please Mail to: _____

OR **Fax:** _____

OR **Patient will pick-up** (circle)

Please include all selected below:

____Entire Record ____Operative Report ____History/Physical ____Progress/Doctor's Notes

____Laboratory/Pathology Report ____X-ray/MRI/CT/US Reports ____X-ray Images ____EKG

____ Other _____

I request that my records be delivered as(circle one): Paper copies **OR** Digital(thumb drive)

******Medical records cannot be emailed******

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under “released from” and "release records to." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
Signature of patient or legal representative Date Signed