Medical Records Release Form

To: _____
Doctor or Hospital

_____
Address

I hereby authorize and request you to release to:

Name: _____

Address: _____

Phone: _____ Fax: _____

The complete medical records in you possession concerning my illness and/or treatment:

Time Period: _____ To: _____

Reason for release: _____

I understand that this authorization authorizes the release if all medical rerecords including psychiatric, alcohol, drug abuse, and HIV/AIDS records. The use of this information may be protected by Public Law 93-255, section408: Public Law 93-282, Section 333: federal Regulation 421 CFR, Part 2. The information provided is confidential and any disclosure by the recipient is prohibited.

_____ _____
Patient or Nearest Relative Relation to Patient

_____ _____
Witness Date

_____ _____
Printed name of patient Patient's date of birth

_____
SSN

R. Bachireddy, M.D., F.A.C.C. V.R. Kovvali, M.D., F.A.C.C. R.V. Kedia, M.D., F.A.C.C.
J.S. Chandra, M.D., F.A.C.C. Kevin L. Hudson, D.O., F.A.C.C M. Musa Khan, M.D., F.A.C.C.
C.K. Mani, M.D., F.A.C.C. Yugandhar Manda, M.D., F.A.C.C. Illyas M. Khan, M.D., F.A.C.C.
A. Solhpour, M.D., F.A.C.C. Sireesha Garikipati, M.D., F.A.C.C. Satish Velagapudi, M.D., F.A.C.C

Lufkin Office
310 Gaslight Blvd
Lufkin, Texas 75904
936-632-8787 \ 936-632—7841 fax \ 800-877-7227

Livingston Office
1717 Hwy 59 Bypass, Suite B
Livingston, Texas 77351
936-327-7733 \ 936-327-2248 fax