Texas Rheumatology

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Authorization to Obtain Medical Information

Patient Name: _____ Date of Birth: ____/____/____

Previous Name: _____

I hereby authorize _____ to release healthcare information of the patient named above to **Texas Rheumatology.**

☐ League City
3725 E League City Pkwy, Ste. 200
League City, TX 77573
Fax: 281-957-9157

☐ Pearland
11555 Magnolia Pkwy, Ste 110
Pearland, TX 77584
Fax: 832-230-1426

This request and authorization apply to:

- ○ All healthcare information, including HIV/AIDS and mental health information.
- ○ Health information related to the following treatment/condition/dates:

  _____

- ○ Only Diagnostic Studies (Lab/Radiology/Biopsy/etc.):

  _____

This authorization is valid for 12 months after the date signed. I understand that except for actions already taken, this authorization may be voided by me at any time. This authorization may be revoked by written communication to Texas Rheumatology.

_____ _____
Signature (Patient/Parent/Guardian) Date

_____ _____
Employee Signature Date