Prime Rheumatology Clinic of Houston PLLC
Dr. Gwendoline Menga
Phone (832) 821-5550 Fax (936) 207-4109
17191 St. Luke's Way Suite 220
The Woodlands,TX 77384

Medical Record Request OUT

Patient Name: ____________________ **DOB**:______________

I hereby give my consent to release records **TO**:

Physician Name: ____________________________________

Address: ____

Phone:_____________________**Fax**:_____________________

From: Prime Rheumatology Clinic of Houston, PLLC Dr. Gwendoline Menga

Including the diagnosis and records of any treatment or examination rendered to me during the period of time_____ (date) to _____ (date).

Specifically, the following reports will be included:

__ Progress Notes __ MRI __ X-rays __EKG

__Infusion Report __Labs __DEXA __CT

__EMG/NCS __Other

____(**initials**) I __**do**(or)__**do not** consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results or such disclosure shall be limited to the following specific types of information:

__ Medical Care __ Attorney __ Insurance __ Other

This authorization shall be valid for 120 days from the date of signature. The patient can revoke the authorization in writing at any time prior to expiration date. The patient agrees that a photocopy of this authorization may be considered valid. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damage resulting from the lawful release of my protected health

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Patient Signature Date Witness