MEDICAL RECORDS REQUEST

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW

Patient Name _____ DOB _____ Phone _____

Address _____ City _____ ST _____ Zip _____

A. Person(s) or Organization(s) authorized to provide the information:

Release Records

____ From
____ To

Willy Pezzia, M.D., P.A. & Associates
714 S Peek Rd
Katy, TX 77450
Phone: 281-395-3955
Fax: 281-395-3959

Release Records

_____ From **Name / Facility** _____

_____ To **Address** _____

City _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____

B. Records being sent to Dr. Pezzia's office must be FAXED due to our use of EMR

C. This information is to include: the Complete Health Record

D. These records are to be used for continued medical treatment.

1) I understand that this authorization will **expire** one year from the date signed unless noted. .
2) I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in **A** (above) in writing.
3) I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits if applicable.
4) I may **inspect or copy** any information used or disclosed under this agreement.
5) I understand that if person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would **no longer be protected** by these regulations.

_____

Patient's Signature or Patient's Representative Date

_____

Printed Name of Patient or Patient's Representative Relationship to Patient