Medical Records Release Form

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By signing this form, I, _____

authorize the office of Padma K. Horvit, MD, PA to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the person(s) or entity listed below.

Release my protected health information to the following person(s)/ entity:

Name:_____

Street: _____

City/State/Zip Code _____

Fax number (with area code)_____

Records to be released (medical records, billing, other)_____

_____

Reason for release_____

_____

Patient Signature (or parent, guardian, or legal representative):

_____

DOB of person signing above _____

Date signed_____

By signing this, the terms agreed to are that record requests are fulfilled no later than 15 business days from the day the request is received in the office of Padma K. Horvit, MD, PA. A fee may be charged for preparing and furnishing this information according to the rules set forth by the Texas State Board of Medical Examiners