



9405 Huffmeister Road, Ste. 100
Houston, TX 77095
PH: 281-463-7208 Fax: 281-463-1035
Email: info@houstonfootdr.com

Request for Release of Medical Records

I hereby request my medical records and/or x-rays be released to:

Myself / Doctor

Patient Name: _____ DOB: _____

Address: _____

Phone: _____

Doctor: _____

Phone #: _____ Fax #: _____

Note: _____

Date: _____ Fee: **\$25** _____

Patient's signature: _____

Witness: _____

TEXAS MEDICAL BOARD RULES

Section §165.2. Medical Record Release and Charges: The requested copies of medical and/or billing records shall be furnished by the physician within 15 business days after the date of receipt of the request and reasonable fees for furnishing the information.