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.