SLIM Healthcare Associates

We Win When Our Patients Win

MEDICAL RECORDS RELEASE FORM

I authorize the office of Dr. _____
to release my Medical Records as detailed below.

By signing this form, I authorize the release of confidential health information by releasing my medical records to the Physician/Practice listed below.

Patient Name: _____

Date of Birth: _____

Information Requested:

- ◯ Complete Records
- ◯ Medication List
- ◯ Radiology Reports
- ◯ Operative Reports
- ◯ History & Physical
- ◯ Pathology Reports
- ◯ Hospital Records

Please release my medical records to the attention of:

- ☐ Dr. Ranganath Kandala
- ☐ Dr. Aparna Tamirisa
- ☐ Dr. Tamirisa Renu
- ☐ Dr. Vijay Korimilli

3519 Town Center Blvd S, Ste B
Sugar Land, TX 77479
Ph: (281) 240-0311
Fax: (281) 240-0313

Patient's Signature: _____ **Date:** _____