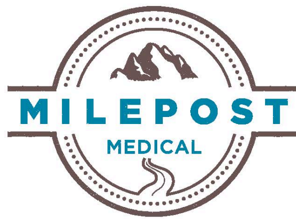

18220 State Highway 249, Suite 335
Houston, Texas 77070

Authorization to Transfer Medical Records

Please send information including diagnosis and records of any treatment or examination rendered to ____________________________________ ("Patient"), DOB ________________.

☐ To: Milepost Medical
18220 State Highway 249, #335
Houston, TX 77070
Phone: 832.912.4820
Fax: 832.463.5065

From: ___________________________
____
____
____

☐ From: Milepost Medical
18220 State Highway 249, #335
Houston, TX 77070
Phone: 832.912.4820
Fax: 832.463.5065

To: ___________________________
____
____
____

Reason for Transfer:

- ☐ Moving to a new area
- ☐ Transferring care to new physician
- ☐ Continuing care
- ☐ Continuing Sleep Medicine Care

Comments:____
____
____

I hereby authorize you to release information including the diagnosis and records of any treatment or examination rendered to Patient to Milepost Medical, P.A. during the period from ________________ to ________________. I am aware that the records released may contain information relating to psychiatric or psychological testing, physical testing, physical abuse, or drug and alcohol abuse, and HIV/HTVL/AIDS results.

____

Patient or Guardian Signature   Date

____

Relationship to patient, if guardian signed

____

Witness   Date