Arturo G. Gonzalez, MD, FACS

General Surgery

REQUEST FOR INFORMATION

I HERBY AUTHORIZE (PREVIOUS DOCTOR OR FACILITY) **PHONE** **FAX**

STREET ADDRESS **CITY** **STATE** **ZIP**

TO FURNISH A COPY OF MEDICAL RECORDS, THIS MAY INCLUDE INFORMATION CONCERNING THE RESULTS AND/OR TREATMENT OF HIV, AIDS, MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE, OF THE PATIENT LISTED BELOW UPON MAKING REQUEST. I HEREBY RELEASE YOU, YOUR PHYSICIAN AND EMPLOYEES FROM LIABILITY FOR FOLLOWING THIS AUTHORIZED RELEASE FORM.

TO: MEDICAL RECORDS
Minimally Invasive & Robotic Surgery, PLLC
2222 Greenhouse Rd, Suite 1800 Houston, TX 77084
Telephone 713-464-2100 Fax 281-829-1950

****PLEASE COMPLETE ALL INFORMATION, INCOMPLETE OR ALTERED FORMS WILL NOT BE PROCESSED****

DATE OF SERVICE: FROM _____ TO _____ (PLEASE CHECK ONE)

- OFFICE NOTES
- LABS
- OPERATIVE REPORTS
- ALL RECORDS

THIS AUTHORIZATION IS VALID FOR 120 DAYS FROM THE DATE OF SIGNATURE.
ANY CHANGE IN AUTHORIZATION MUST BE IN WRITING.

PATIENT NAME	DATE OF BIRTH
SS NO.	PHONE
ADDRESS	CITY, STATE ZIP
PATIENT SIGNATURE **GUARDIAN, IF MINOR**	**DATE**

FOR OFFICE USE ONLY

DATE REQUESTED_____REQUESTED BY _____

THIS DOCUMENT OR DOCUMENTS ACCOMPANYING THIS TRANSMISSION MAY CONTAIN CONFIDENTIAL HEALTH INFORMATION THAT IS LEGALLY PRIVILEGED. THIS INFORMATION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. THE AUTHORIZED RECIPIENT OF THE INFORMATION IS PROHIBITED FROM DISCLOSING THIS INFORMATION TO ANY OTHER PARTY UNLESS REQUIRED TO DO SO BY LAW OR REGULATION AND IS REQUIRED TO DESTROY THE INFORMATION AFTER STATED NEED HAS BEEN FULFILLED. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, DISTRIBUTION, OR ACTION TAKEN IN RELIANCE ON THE CONTENTS OF THESE DOCUMENTS IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS INFORMATION IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATLEY AND ARRANGE FOR THE RETURN OR DESTRUCTION OF THESE DOCUMENTS.