MEMORIAL AND KATY SURGICAL SPECIALISTS

General, Breast and Laparoscopic Surgery

Kevin D. Wheeler, M.D., F.A.C.S.
Cameron R. Ruttman, M.D.
Enrique M. Sta. Ana, M.D., F.A.C.S.

I hereby consent to and authorize Memorial and Katy Surgical Specialist to release my medical records.

Patient Name: ____

Address: ____

City, State and Zip Code: ___________________________________

Date of Birth: _______________Phone: _______________________

Records to use or disclose to

Name of person or facility: __________________________________

Practice Address: ____

City, State and Zip code: ____________________________________

Email: ______________________ Fax: ________________________

Please select all the specific documents that apply to your request:

- o Completed Medical Records
- o Consultation Report
- o Discharge Summary
- o Radiology Reports
- o Lab Results
- o Pathology Results
- o Operative Reports
- o Other

Please place your initials next to the below to authorize release of sensitive information pertaining to:

Mental Health ____ Drugs/Alcohol ____ Genetic Testing _____ HIV/Aids/ other infection diseases ____

Please select the purpose of your request:

- o Continued Patient Care
- o Worker's Compensation
- o Attorney/Legal
- o Insurance
- o Personal
- o Social Security/ Disability
- o Other

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Print Patient Name Patient Signature Date

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