MEDICAL CLINIC OF BELLAIRE, P.A.
DR. ESTHER GUY

Release of Medical Records

Today's Date: _____

To:*(Physician's Name)* _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

I _____ *(Date of Birth)* _____ hereby request that any/all of my medical records be released to my Primary Care Physician:

Dr. Esther Guy

5959 West Loop South Suite 510 Bellaire, TX 77401

Phone:(713)526-5606 Fax:(713)526-0058

Records to include the past 3-5 years only.

_____ Labs _____X-ray/Radiology/EKG _____Progress Notes _____Procedure Notes

Other:_____

_____

_____

Patient Signature: X_____ Date: _____

Print Name: _____