Jose M. Ortega, MD, FACS, PA

Diplomat American Board of Surgery • Fellow of American College of Surgeons

Laparoscopic & General Surgery

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date: _____

To: _____

_____

_____

RE: _____ DOB:_____ SS#_____

The above named patient who is presently being seen in our office states that he/she was previously treated in your office and/or facility. To better evaluate this patient, it is requested that the record(s) below be forwarded to our office.

The records desired are:

_____ Final summary, report(s) of treatment rendered, or copy of medical records.

_____ X-Ray Films and/or reports

_____ Other, as follows _____

This information is requested by:

Jose M. Ortega, M.D., FACS
18955 Memorial North, Suite 480
Humble, Texas 77338
Office 281-319-5319
FAX 281-319-4424

Your prompt attention to this request is appreciated.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize and request a copy of my medical records from _____

Patient / Guardian Signature: _____

Witness: _____