



OFFICE: 713.575.3686 • REFERRAL FAX: 713.575.3688 • www.TexasEVA.com

MEDICAL RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

This is Form intended as a Release of healthcare Information to: [Texas Endovascular](#)

I _____ (please print clearly) request and authorize the release of Healthcare Information including the diagnosis, records; physical examination, diagnostic imaging, labs and treatment plan rendered to me. This information may be released to:

[Texas Endovascular](#)

4747 Bellaire Blvd., Suite 575
Bellaire, TX 77401

1331 W. Grand Prky N., Suite 210
Katy, TX 77493

Should you have any questions, Please call my: my home my work my cell

Number: _____ Alternate number: _____

If unable to reach me:

You may leave a detailed message

Please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Patient signature:

Date: ____/____/____ Time: _____AM/PM

Special Instructions/Request:
