CONSENT TO REQUEST MEDICAL RECORDS

I , The Patient/Responsible Party ________________________________
Authorize **Medicus Internal Medicine & Primary Care PLLC, dba Katy Fulshear Internal Medicine, Sarwat Makkani, DO** to Obtain Medical Records From:

Practice/Hospital: ____

Phone: ____

Address: ____

____

Patient/Responsible Party: ______________________________________

DOB: ___/____/_____

Sign: ________________________________

Date: _____/____/________