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: _____

_____

☐ By checking this box, I agree to receive SMS messages about communications from Katy Fulshear Internal Medicine. The SMS frequency may vary. Data rates may apply. Text HELP for assistance. Reply STOP to opt out of receiving SMS messages

Patient/Responsible Party: _____

DOB: ___/____/_____

Sign: _____

Date: _____/____/_____