



Karen Thampoe, MD
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Katy, Texas 77450

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Authorization for Release of Medical Records & Information

I authorize and request Dr. _____ to release all of my medical information/records (including, but not limited to, information on psychiatric conditions, medical illness, alcohol and drug abuse, and HIV or communicable diseases) to Dr. Karen Thampoe for my continued Medical Care. Please send all medical records on my behalf to:

Dr. Karen Thampoe
705 South Fry Road, Suite 105
Katy, Texas 77450
Telephone: 281-500-8176
Fax: 281-500-8178

I agree that these provisions will remain in effect until I provide written revocation to Karen Thampoe, MD, PA.

Medical Record to be released by: _____

Address: _____

Phone: _____

Signature of Patient/Legal Guardian: _____

Print name of Patient/Legal Guardian: _____

Date: _____