



Altus Cancer Center – Jonathan Cheng M.D Ph.D
1626 W. Baker Road,
Baytown, Texas 77521

281.837.7600 Fax: 281.837.7611

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ **Patient I.D:** _____

Date of Birth: ___/___/___ **SSN:** _____

I request and authorize Altus Cancer Center to release or retrieve a complete copy of my medical records to or from:

Facility: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

This request and authorization applies to:

Film(s) or CD **Complete Medical Records**

Report (MRI, CT, OR, NUC, PET CT)

Relating to the following studies and dates:

Patient's Signature: _____ **Printed Name:** _____ **Date Signed:** _____

Charges:

Medical Records: \$8.00 of films/CD for Imaging/ \$ 32.50 for Complete Medical Records.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.