Irfan Lalani, MD, PA
Interventional Pain, Neurodiagnostics and Rehabilitation

Methodist Sugar Land Hospital
Medical Office Building 3
16605 Southwest Freeway Suite #320
Sugar Land, TX 77479
Phone: (281) 265-0225
Fax: (281) 265-2219

Medical Records Request Form

Authorization For Disclosure of Health Information

This is a request for medical records for the following patient:

Patient Name: _____

Patient Address: _____

Patient DOB: _____

Patient SSN: _____

Information to be disclosed:

□ ALL MEDICAL RECORDS ON FILE
□ All Laboratory Tests
□ All Imaging and Radiology
□ All History and Physicals
□ All Progress Notes
□ All Current Medications
□ All EMG Tests
□ Other _____

Information to be disclosed to:

Irfan Lalani, MD, PA
Neurology and Pain Medicine
16605 Southwest Freeway Suite #320
Sugar Land, TX 77479
Phone: (281) 265-0225
Fax: (281) 265-2219

I, _____, do hereby authorize the release of all my medical records to Dr. Irfan Lalani and staff; including imaging, labs, office visit notes, Rx history and any other medical information relevant to my care. This authorization maybe revoked in writing at anytime, and disclosed information may be subject to redisclosure by Dr. Lalani and staff.

_____ _____

Signature of Patient or Qualified representative Date

Irfan Lalani, MD, PA

Interventional Pain, Neurodiagnostics and Rehabilitation

Patient Information

First Name: _____ Middle Name/Initial: _____

Last Name: _____ DOB: _____ Gender: □ Female □ Male

Emergency Contact (Not living with you)

Contact Name:_____ Relationship:_____

Home Phone #:_____ Cell Phone #:_____ Alternate Phone #:_____

Doctors

Do you have a Primary Care Doctor: □ Yes □ No If yes, Primary Care Doctor Name:_____

If No, would you like us to refer you to a Primary Care Doctor: □ Yes □ No

How did you find out about us? □ Referred by Doctor _____

□ Internet _____ _ □ Friend _____ □ Magazine _____

□ Methodist Spine Center □ Hospital ER _____ □ Other

_____

Patient History

Principal Reason for seeing Dr. Lalani:_____

How long have you had this problem:_____

Any Other Neurological Issues:_____

Social History

Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Occupation Status: □ Employed Full Time □ Employed Part Time □ Disabled □ Retired

Employer/Company Name:_____ Occupation/Job Title: _____

Employer Address:_____ City:_____ State:_____ Zip:_____

Student: □ Yes □ No Name of Institution:_____

Please check any of the following tests that you have had to diagnose your current problem.

□ CT Scan Facility Used: _____ Date of Scan: _____ Ordered by Dr. _____

□ MRI Scan Facility Used: _____ Date of Scan: _____ Ordered by Dr. _____

□ EMG Facility Used: _____ Date of Test: _____ Ordered by Dr. _____

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Please list ALL CURRENT medications:

MEDICATION NAME	DOSAGE
EXAMPLE: **IBUPROPHEN**	***EXAMPLE:*** **200mg three times a day**

Allergies/Intolerance

Please list all medications that you are allergic to and describe the reaction:

Medication	Reaction