NOTICE OF PRACTICE CLOSURE

Lugo Surgical Group • Rafael Lugo, MD

Lugo Surgical Group permanently closed on Monday, July 27, 2026.

Thank you for the privilege of caring for you. Although the practice has closed, your medical records remain available to you, and we want to make obtaining them as easy as possible.

HOW TO REQUEST YOUR MEDICAL RECORDS

The easiest and fastest way to request your records is to send us a message through MyChart. You may also contact us any of the following ways:

MyChart:	**Send a records request message (preferred)**
Phone:	**(832) 377-5846**
Email:	**drlugo@lugosurgicalgroup.com**
Fax:	**1-888-416-9722**
Mail:	**Lugo Surgical Group 10800 Gosling Road, Unit 131330 Spring, TX 77393**

When requesting records, please include your full name, date of birth, a phone number where we can reach you, and where you would like the records sent.

NEED A REFERRAL OR FUTURE CARE?

If you need a referral to another physician for any condition we treated while the practice was open, please forward us a message through MyChart or by email, and we will indicate where you should go for care. If you had surgery with us, you have most likely already completed your post-operative follow-up, and no further routine visits should be needed.

If you have a medical emergency, call 911 or go to the nearest emergency room.

With sincere gratitude for your trust over the years,
Rafael Lugo, MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Lugo Surgical Group • Rafael Lugo, MD
10800 Gosling Road, Unit 131330, Spring, TX 77393 • Phone: (832) 377-5846 • Fax: 1-888-416-9722

1. PATIENT INFORMATION

Patient name: _____ Date of birth: _____

Address: _____ Phone: _____

City / State / ZIP: _____ Email: _____

2. AUTHORIZATION

I authorize **Lugo Surgical Group / Rafael Lugo, MD** to release and disclose my complete medical record, including but not limited to: office and clinic notes, history and physical examinations, consultation reports, operative and procedure reports, pathology reports, laboratory results, imaging and radiology reports, medication lists, and billing records, for all dates of treatment, to the person or entity named below.

Sensitive information. I understand that unless I initial below, this authorization does NOT include the following categories of information. I specifically authorize release of (initial each that applies):

_____ Mental health records (excluding psychotherapy notes) _____ Drug, alcohol, or substance use treatment

_____ HIV/AIDS test results and treatment _____ Genetic information

3. RELEASE RECORDS TO

[ ] Myself (the patient) [ ] Physician / clinic named below [ ] Other (specify below)

Name: _____

Address / Email / Fax: _____

Preferred delivery method: [ ] MyChart [ ] Email [ ] Mail [ ] Fax

4. PURPOSE

[ ] Continuing medical care [ ] Personal use [ ] Insurance / legal [ ] Other: _____

5. EXPIRATION, REVOCATION, AND MY RIGHTS

This authorization expires one (1) year from the date signed, unless I specify an earlier date or event here: _____. I understand that: (a) I may revoke this authorization at any time by written notice to the practice at the address above, except to the extent action has already been taken in reliance on it; (b) treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization; (c) information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy law; and (d) I am entitled to a copy of this authorization. A copy, facsimile, or electronic image of this authorization is as valid as the original, and an electronic signature is as valid as a handwritten signature.

6. SIGNATURE

Signature of patient or personal representative:

_____ Date: _____

If signing as personal representative, relationship / authority:

Printed name: _____ _____