Authorization for Disclosure of Health Information

I hereby authorize ____

To release medical information from the records of:

Patient Name: _______________________________________ DOB: ___________________

Address: ____

DATES of Treatment Requested: ____

Information to be disclosed (check all applicable Items to be released):

____ Discharge summary ____ ER Records ____ Progress Notes ____Treatment plans
____Discharge Instructions ____X ray reports ____Medication records ____Commitment papers
____ History & Physical ____Labs ____Doctors orders _____ HIV testing
____ Consultations ____EKG / ECG tests ____ Nurse's notes _____ Therapy Notes
____ Operative report ____ Other (Specify) : ____

PURPOSE OR NEED FOR THE DISCLOSURE IS:
---- Continued Medical care ____Insurance ____Legal ___Personal use ___Other : ______________

The Information May be disclosed to

Shazia F Sheikh, MD

23211 Red river dirve, Katy Texas, 77494

PH : 832 437 2427 FAX: 281- 396-4798

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, Acquired Immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and or Human Immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with state copying laws.

X ____ Date: ___________________________

(Signature of Patient or Patient representative)

If signed by a personal representative, a description of the representative's authority to act is as follows:

___ Parent ___Legal Guardian ___ Health care Power of authority

___ Administrator ____Executioner of Estate ____Next of Kin ____ Beneficiary