WESTCHASE HEALTH CLINIC

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

I authorize the transfer of my healthcare information

From: _____

_____

_____

_____

Phone: _____

To: Dr. Tanveer Syed , M.D.

12121 Richmond Ave.

Suite 225

Houston, Texas 77082

Phone: 281-556-0200
Fax: 281-556-0205

Health Information Requested:

- ☐ Complete Medical Records
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Hospital Records
- ☐ Imaging Reports
- ☐ Laboratory Reports
- ☐ Other (specify) _____

Reason for Disclosure: Continuing patient care

Other: _____

Limit Records to: _____

I understand that the specific information to be released may include but not limited to management of drug or alcohol abuse, mental/psychiatric illness or communicable disease. I understand this consent may be revoked at anytime in writing.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE.

_____

Printed Name | Date of Birth

_____

Signature | Date

_____

Signature of Patient Representative | Relationship to patient | Date

12/14/07