

Renal Physicians of Montgomery County, P.A.

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102A Medical Park Lane Huntsville, TX 77340 936-756-2555

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME	DATE OF E	BIRTHSS#	
\DDRESS		TELEPHONE	
I, HEREBY REQUEST AND AUT	THORIZE:		
Name of physician or institution)	(Telephon	e number)	(Fax number)
(Sireet)	(City)	(State)	(Zip)
REN	ROM THE MEDICAL RECORDS AL PHYSICIANS OF	ГО:	
(Name of physician or institution 100 Riv	OMERY COUNTY, PA er Pointe Dr. Ste. 120 (Telephone roe, Texas 77304	e number)	(Fax number)
(Street)	(City)	(State)	(Zip)
TREATMENT DATES		FOR THE FOLLOW	ING PURPOSES:
MEDICAL CARELEG	GALINSURANCE	_OTHER (DETAIL E	BELOW)
psychiatric, HIV testing, I, the undersigned, have read the information as herein contained. I understand the information as herein contained. I understand the interest to re-disclosure by the recresponsibility and liability resulting	by consent to such, that the release HIV results, or AIDS information. above and authorize the staff of inderstand that this consent may be winderstand that when this information cipient and may no longer be protegifrom release of this information are an interest in the matter, all provi	withdrawn by me at any time excert is used or disclosed pursuant to ected. This facility is released and I, the undersigned, waive, or	to disclose such that to the extent that action has this authorization, it may be and discharged of all legal to behalf of myself, my heirs
Date)			
uurej	Signature of patient, parent, cons	ervator, guardian) (Authority: relation	ship to patient)
BARRY N. NEELAND, M.D	DARSHAN V. TOLAT, M.D.	MICHAEL J. WALLS, M.D.	SYED M. ZAIDI, M.D.