Mark Jacobs, MD, P.A.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Name: _____

Date of Birth: _____

I hereby authorize and request:

Mark Jacobs, MD
7580 Fannin, Suite 220
Houston, Texas 77054

to forward the last **two (2) years** of my medical records to the following(please check one):

☐ **Myself**
Address: _____

☐ **My Physician**
Name: _____
Address: _____

☐ **Designated Individual**
Name: _____
Relationship: _____
Address: _____

Signature of Patient: _____

Date: _____