AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information: (Please Print)

Name: ____ Date of Birth: ____________

Social Security Number:____

City:_____________________________ State: _______________ Zip Code: ____________

Phone Number: ____________________________ Fax Number: ____________________

Please release my medical records from:

Clinic Name: _____________________________________

Tel. Number: _____________________________________

Fax Number: _____________________________________

To:

Jamil C. Mohsin, MD, FACC, FSCAI
13215 Dotson road, Ste. 340
Houston, Texas 77070
Office: (832) 688-9479 eFax: (832) 604-7466

Please send medical Records no later than: ________________________________

Please release a copy of all my medical records, including but not limited to progress notes, operative notes, laboratory results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MY MEDICAL RECORDS:

patient signature:_______________________________________date:__________________