AUTHORIZATION FOR RELEASE AND TRANSFER OF MEDICAL RECORDS

Date _____

To _____

(Doctor/Clinic/Hospital)

Address _____

City _____ State _____ Zip Code _____

I hereby authorize the release of all my medical records or copies of such and request that they are transferred to:

FARZANA SAHI, M.D., P.L.L.C.
7777 SOUTHWEST FREEWAY, SUITE 640
HOUSTON, TX 77074
TELEPHONE: (713) 270-0477
FAX: (713) 270-7655

_____ _____

Print Name of Patient Social Security Number of Patient

_____

Date of Birth

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Witness Date