Authorization to Release Patient Medical Information

I hereby authorize Dr. ___________________________ (Previous Doctor's Name)

____________________________ (Address)

____________________________ (City, State, Zip)

____________________________ (Telephone)

__________________________ (Fax #)

To release all information in my medical files to:

TSO MISSOURI CITY
Dr.'s Amit & Rita Shah
10330 Highway 6, Suite E
Missouri City, Texas 77459
PH: 281-431-1000
FAX: 281-476-7062

____
Signature (Patient OR Parent if minor)

____
Printed Name

____
Address

____
City, State, Zip

____
Patient Date of Birth

____
Phone