AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
MEDICAL RECORDS DEPARTMENT

Patient Name: _____ DOB: _____
Address:

_____

Home Phone: _____Cell Phone: _____Work Phone:

_____

HEALTH CARE FACILITY/FACILITIES:

I authorize representatives from the following to disclose the health information as directed below:
NAME: _____
ADDRESS:

_____

PHONE NUMBER: _____ FAX NUMBER:

_____

RECEIVING PARTY:

Please send my health information to:

DR. DIANA EISNER
2030 N. LOOP WEST #125
HOUSTON TX, 77018
PHONE: 713-688-8393
FAX: 713-688-0595

DESCREPTION OF HEALTH INFORMATION TO BE DISCLOSED:

□ Complete Medical Records
□ Partial Medical Record (Please Check Specific Sections Needed Below):
- □History & Physical
- □Consultations
- □Discharge Summary
- □Lab Results
- □Office Notes
- □Other: _____Please send Immunization record

ASAP_____

_____ _____
Signature of Patient (Patient Representative) Today's Date

_____ _____
Witness Signature Today's Date