Digestive & Liver Center, P.A.
Medical Records Release Form

Patient: _____ Date of Birth: _____

Social Security Number: _____

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or otherwise release confidential information. _____

- ☐ Complete record
- ☐ Records of care from the following date _____ to _____
- ☐ Records concerning the following conditions: _____
- ☐ Other, Please specify: _____
- ☐ Confer with person(s) listed below verbally about my medical information:

_____

HIV/AIDS; I consent to release of any positive or negative test results for AIDS OR HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Initial: _____ Date: _____

Release to the following person(s)/entity:

- ☐ Nizam Meah, M.D. 109 Parking Way
  Lake Jackson, TX 77566
- ☐ Family/Spouse (name): _____
- ☐ Other (please fill in) _____

The reasons or purpose for this release of information are as follows:

_____

_____

_____

Signature: _____ Date: _____

Parent or Guardian in relationship
(If applicable)

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be a charged to the requesting patient according to rulings set forth by the Texas State Boards of Medical Examiners.

PRINT