PREMIER Oncology CONSULTANTS

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ hereby authorize the following Physician / Hospital / Laboratory / Therapy or Imaging Facilities:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

ATTN: _____

To disclose and release complete health record including, but not limited to, diagnoses, lab test / results, radiology, pathology, treatment plan, and billing records for all conditions of myself, release to:

☐ *Dr. Shagufta Naqvi*
☐ *Dr. Mohammad Riaz*
PREMIER ONCOLOGY CONSULTANTS
9230 KATY FREEWAY, SUITE 410
SPRING VALLEY MEDICAL PLAZA
HOUSTON, TEXAS 77055
PHONE: 281-556-6622 (MAIN)
FAX: 281-647-7767 (CENTRAL)

☐ *Dr. Shagufta Naqvi*
☐ *Dr. Mohammad Riaz*
PREMIER ONCOLOGY CONSULTANTS
18400 KATY FREEWAY, SUITE 320
HOUSTON METHODIST WEST- BLDG #1
HOUSTON, TEXAS 77094
PHONE: 281-647-7766 (KATY)
FAX: 281-647-7767 (CENTRAL)

Records Requested:

_____

_____

_____

The information may be released or disclosed in printed and/or digital format. A photocopy of this assignment is to be considered as valid as the original until revoked in writing.

_____ _____
Print: Patients / Representative Name Patients DOB

_____ _____
Signs: Patients / Representative Signature Date