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 a 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
410 W GRAND PARKWAY S, SUITE 4C
PARK PLAZA
KATY, TEXAS 77494
PHONE: 281-556-6622 (MAIN)
FAX: 281-647-7767 (CENTRAL)

☐ *Dr. Shagufta Naqvi*
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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