



### CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

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

NAME: \_\_\_\_\_

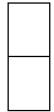
ADDRESS: \_\_\_\_\_

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*

*Dr. Mohammad Riaz*

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KATY, TEXAS 77494  
PHONE: 281-647-7766 (KATY)  
FAX: 281-647-7767 (CENTRAL)

Records Requested:

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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.

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Print: Patients / Representative Name

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Patients DOB

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Signs: Patients / Representative Signature

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Date