Digestive & Liver Specialists of Houston

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Authorization to Release Medical Records

I hereby authorize and request you,

_____
(Doctor / Hospital)

_____
Address

_____
City, State, Zip

_____
Phone, Fax Numbers

To release to Digestive & Liver Specialist of Houston, the complete history records in your possession concerning my illness and/or treatment during the period from:

_____ to _____

Patient Name: _____ Date of Birth: _____

Address: _____

_____

Signature : _____ Date :_____

Please mail or fax to: Digestive & Liver Specialists of Houston
915 Gessner, Suite 850, Houston, TX 77024
Phone # 713.461.1026 Fax # 713.461.4358