WESTSIDE MEDICAL CLINIC

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

I authorize the transfer of my healthcare information from:

Dr. ____

Clinic/
Hospital: ____

Address: ____

____

Phone: ____

Fax: ____

To: Dr. Syed V. Ahmed, M.D.

3760 South Mason Rd #10

Katy, Texas 77450

Phone: 281-398-2900

Fax: 281-398-9990

Health Information Requested:

- ☑ Complete Medical Records
- ☐ Last Consultation Reports
- ☐ Discharge Summary
- ☑ IMMUNIZATION RECORD
- ☐ Hospital Records
- ☐ Imaging Reports
- ☐ Laboratory Reports
- ☐ Other (specify) ______________________________

Reason for Disclosure: ☑ Continuing patient care ☐ Other: ______________________________

Limit Records to: ____

I understand that the specific information to be released may include but not limited to management of drug or alcohol abuse, mental/psychiatric illness or communicable disease. I understand this consent may be revoked at anytime in writing.

THIS CONSENT WILL EXPIRE 180 DAYS AFTER DATE OF SIGNATURE.

Last Name	**First Name**	**Middle Initial**	**Date of Birth**

Previous Names	**Social Security**

Signature	**Date**

Signature of Patient Representative	Relationship to patient	Date