Ranjit S. Grewal, M.D., PA
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Cypress, Texas 77429
Office: (281) 477-0525
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Release of Information

Name:_____DOB:_____Date:_____

I hereby consent to and authorize (name of physician*)*_____
Physician phone number: _____ Fax number: _____

To **RELEASE TO Ranjit S. Grewal, M.D.,** information concerning the history, treatment, examination, and/or hospitalization of the above patient. I understand that the specific type of information to be release includes:

Complete Medical Records
History and physical
Labs, Radiology, EKG
Operative/ Procedure
Consultation Report
Other (*please specify)*_____

_____ **I Do or** _____ **I DO <u>NOT</u>** authorize the release of portions of the record relating to substance abuse, psychological/ psychiatric conditions and/or communicable disease, including Acquired Immunodeficiency Syndrome (AIDS), or tests for infection with Human Immunodeficiency Virus (HIV), if present.
I understand that this consent is revocable except to the extent that action has already been taken. This consent will automatically expire 90 days from date of signature, unless another date is specified below (*).

NOTE: UNLESS OTHERWISE PREMITTED BY LAW, FURTHER RELEASE OF THIS INFORMATION IS PROHIBITED WITHOUT MY PRIOR WRITTEN CONCENT.

Signature of patient or Legal Representative: _____ Date_____

State Relationship to Patient: _____

Signature of Witness: _____ Date:_____

_____ Mailed _____Picked –Up _____ Faxed

Contact Name (for questions) _____ Phone Number: _____