19255 Park Row, Suite-104 Houston, TX 77084 Phone: (281) 945-5190 Fax: (855) 324-3438
Email: info@katystomachdr.com

Patients Name: ______________________________ DOB: ______________________

Address: ______________________________ Telephone #: __________________

____

____

☐ **I hereby authorize Dr. James Maher to release or receive** the following information to/from the specified facilities and/or person(s) listed below. (check all that apply)

- ☐ All Medical Records
- ☐ Lab Results
- ☐ All Radiology Reports
- ☐ Pathology Reports
- ☐ Discharge Summary
- ☐ Colonoscopy / EGD
- ☐ Progress Notes
- ☐ Operative Reports

Release my records to / from:

Facility: ______________________________ Address: ______________________________

City/State/Zip: ______________________________ Phone: ______________________________

Fax: ______________________________

By signing this form, I AUTHORIZE YOU TO USE AND DISCLOSE THE PROCTECTED HEALTH INFORMATION DESCRIBED BELOW.

Patient: ______________________________ DOB: ______________ DATE: __________________

Witness/Title: ______________________________ DATE: ______________________

Release my protected health information to the following offices:

James Maher, M.D
19255 Park Row suite 104 Houston, Texas 77084
Phone Number: 281-945-5190 Fax Number: 855-324-3438

THE REASONS OR PURPOSE FOR THIS RELEASE OF INFORMATION ARE AS FOLLOWS:

1. ____

2. ____

***Authorization will expire 3 months from date above.**
***I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIMEBY SENDING A WRITTEN NOTIFICATION TO THE PRACTICE.**