James Maher, M.D.
Board Certified
GASTROENTEROLOGY

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.**