TEXAS ARTHROSCOPY AND SPORTS MEDICINE INSTITUTE

Omer A. Ilahi, MD
ORTHOPEDIC SURGERY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
(Please Print)

I, the undersigned, hereby authorize _____ to release medical records to:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

To release the medical information described below: *(please check)*

_____ All Medical Records

_____ Records Dating _____ to _____

_____ Other _____

_____ _____
Signature of Patient or Parent/Guardian **Date**

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Houston, Texas 77030
(713) 800-1100
(713) 800-1101 Fax

4201 Garth Road, Suite 111
Baytown, Texas 77521
(281) 428-1001
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