AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize____

____

____

to furnish full details of the medical care and treatment:

patient's name: ____

S.S.#____

D.O.B.____

To: Gordon H. Newman, M.D./Larry R. Taub, M.D./Claire Y. Chu, M.D.

5744 LBJ Freeway, Suite 150	1708 Coit Rd., Ste. 240
Dallas, Texas 75240	Plano, TX 75075
(972)392-2020 fax (972)392-4054	(972) 312-9312 fax(972) 312-9369

Patient signature____

Witness____

Relationship to patient____

Please include:____

____