



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.

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(972)392-2020 fax (972)392-4054 (972) 312-9312 fax (972) 312-9369

Patient

signature _____

Witness _____

Relationship to patient _____

Please

include: _____
