Moonat Medical Assoc Inc.
17030 Nanes Drive. Suite 211. Houston, TX 77090
Ph: (281) 440-5925 Fax: (281) 440-3324

AUTHORIZATION TO RELEASE INFORMATION

I. Patient's Information:

Name: _____

Date of Birth: _____

Address: _____

_____

_____

Tel. No. (Home): _____ **(Work)**_____

II. Details of a Person(s) to whom the information to be released:

Name: _____

Relationship with Patient: _____

Address: _____

_____

Tel. No. (Home): _____ **(Work)**_____

I DECLARE that the above-mentioned person is authorized to collect the details of my medical reports/health conditions/ any other details from your office in my absence or on behalf of me.

Patient's Signature _____ **Date** _____