George Nunez, Jr., M.D.
Gastroenterology and Hepatology

Diplomate of the American Board of Internal Medicine
Certified in the Subspecialty of Gastroenterology

Request for Medical Records

TO: _____
Medical Facility or Physician

_____
Address

_____
City State Zip

I hereby authorize the above named Facility and Dr. George Nunez, Jr. M.D. to use and disclose protected health information from the records of myself. I understand that the records used an disclosed pursuant to this authorization form may include information relating to: HIV infection or AIDS; treatment for or history of drug or alcohol abuse, or mental or behavioral health or psychiatric care. I hereby authorize the release of all my records including (Operative , Pathology, Laboratory, Radiology, EKG reports, H& P's, Discharge Summary and consultations.) I understand that copies of the records will be mailed or faxed to 281-348-9510. I understand that I may revoke this authorization in writing at any time by sending or faxing a written notice to Dr. Nunez, stating my intent to revoke this authorization.

_____
Patient Name—Print

_____
Social Security #

_____
Signature

Patients Phone # _____

_____
Date of Birth

_____
Date

For the period indicated:

_____ All available records

_____ from _____ to _____

_____ Specific test or study results _____

Please forward to :

GEORGE NUNEZ, JR MD, PA
201 Kingwood Medical Dr.
Suite B-600
Kingwood, TX 77339