George Nunez, Jr., MD, PA

201 Kingwood Medical Drive, Suite B-600
Kingwood, Texas 77339
281-358-3702 office
281-348-9508 fax

Request for Medical Records

To: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the above named facility and George Nunez, Jr., MD to use and disclose protected health information from my healthcare record. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: HIV infection or AIDS, treatment for or history of drug or alcohol abuse, mental/behavioral or psychiatric care. I hereby authorize the release of all my records including: operative, pathology, laboratory, radiology, EDG reports, H & P's, discharge summaries and consultations. I understand that I may revoke tis authorization in writing at any time by sending or faxing a written notice to George Nunez, Jr., MD stating my intent to revoke this authorization.

_____ _____
Patient Name Social Security Number

_____ _____
Signature Patient's Phone Number

_____ _____
Date of Birth Date

For the Period indicated: *(Please check the appropriate box)*

☐ All available records

☐ Only those records from _____to _____

☐ Specific test or study results: _____