Gastrointestinal Care Consultants, P.A.

Madhukar Kaw M.D. Tojo Thomas M.D. Shashideep Singhal M.D. Prianka Singapura M.D

PLEASE PRINT

RELEASE OF MEDICAL INFORMATION

RELEASE OF MEDICAL RECORDS

Date: _____ **URGENT**

I hereby authorize:
Physician/Facility/Insurance Co: _____
Address: _____
Tel: _____Fax: _____

To release information regarding my medical history, treatments, disability or benefits to:

GASTROINTESTINAL CARE CONSULTANTS, P.A.
12121 Richmond Avenue, Suite 424
Houston, Texas 77082
Tel: 832-379-8603 Fax: 832-379-1928

PATIENT'S NAME: _____

PATIENT'S DOB: _____PATIENT'S SSN:_____

SIGNATURE: _____

WITNESS: _____

☐ Recent Blood Work ☐ Recent Medical Records

Please Fax all the records to 832-379-1928