By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person (s) or entity listed below. HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Initial:_____ Date:_____

I hereby authorize: [Physician or Facility]_____

To release or receive my medical records from: Munshi Modern Pain

Requested information: (ex: progress notes, Radiology)

_____

Dates of service:_____

Signature of patient:_____ Total pages including Cover:_____

Munshi Modern Pain
Dr. Omer Munshi
12553 Gulf Freeway
Houston, TX 77034
Office: 281-481-8557 ext 3
Fax: 281-929-0804

All attempts will be made to provide this information within 15 days from receipt of this request. Fee's to persons or individuals may apply according to rulings by the Texas State Board of Medical Examiners.