

23920 Katy Freeway Suite 440 Katy , Texas 77494

Phone: 346-257-4300 Fax: 832-437-8650

DEMOGRAPHICS

Date:	Date of Birth:			Age:	Male/Female
Name: First		MI_	Last		
Street Address			Apt. or Po	ost Office Box	
City		Sta	ate	Zip	<u> </u>
Telephone: Primary: ()		Home	_WorkCel	1
Work: ()	Cell: (_				
Email address:					
Marital Status (Please C	Circle): Married	Single	Divorced	Widowed	
Spouse's Name:		Spou	ıse's Phone Nu	ımber :	
Languages Spoken and	Preferred:				
Race: Black / Hispanic /	Native American / As	sian / White	e / Chinese / Fi	ilipino / Native	Hawaiian / Multiracial /
Pacific Islander / Japanes	e / Other				
Employment Status: Ful	ll-Time / Part- Time /	Self-emplo	oyed / Retired	/ Student / Une	employed / Disability
Emergency Contact:			Phone:		
	INSU	JRANCE 1	INFORMATI	ON	
1) Primary In	surance:				
Subscriber Name:			Subscriber	's DOB:	
Relationship to Patient: _			Subscriber's S	SS#	
Insurance ID#:	G	roup #:		Co-Pay:	
2) Secondary	Insurance:				
Subscriber Name:			Subscriber	s DOB:	
Relationship to Patient:			Subscriber's S	S#	
Insurance ID#:	G	roup #:		Co-Pay:	



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rimary Care rilysic	cian				PCP Ph	one		
any other Specialist	s that y	ou are see	ing?					
vnat is the reason is	or your	visit toda	y: _:					
Daily activities you h	nave tro	uble with	due to arthritis/ mu	scle p	oain/stiffne	ess:		
approximate date sy	mptom	ıs began:	Di	agnos	sis Given:			
revious treatments	for this	problem:	(include physical th	ierap	v. surgerie	es, injections, infusions)	
		-		_	_	-		
ersonal & Immedia	ate Med	lical/Dost	M. I'. I TI'. I DI					
erbonar et minioan	ALC ILLO	HCAL/FASE	viedicai History: Pie	ease c	heck all th	at apply below		
	You F	amily	Medical History: Pic	ease c	heck all the Family	at apply below	You	Family
Alcoholism	You F		Diabetes			Osteoarthritis	You	Family
Alcoholism Anemia	You F					,	You	Family
	You F		Diabetes			Osteoarthritis	You	Family
Anemia Ankylosing Spondylitis	You F		Diabetes Epilepsy/Seizure			Osteoarthritis Osteoporosis	You	Family
Anemia Ankylosing Spondylitis Anxiety	You F		Diabetes Epilepsy/Seizure Fibromyalgia			Osteoporosis Osteoporosis	You	Family
Anemia	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout			Osteoarthritis Osteoporosis Osteoporosis Other	You	Famil
Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems			Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia	You	Famil
Anemia Ankylosing Spondylitis Anxiety Arthritis	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease			Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever	You	Family
Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma Blood Clots Blood Disorders	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease Hypertension			Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever Rheumatoid Arthritis		Family
Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma Blood Clots Blood Disorders Breathing Problems	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease Hypertension Irritable Bowel			Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever Rheumatoid Arthritis Restless Leg Syndrome		Family
Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma Blood Clots Blood Disorders Breathing Problems Cataracts	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease Hypertension Irritable Bowel Jaundice			Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever Rheumatoid Arthritis Restless Leg Syndrome Sleep Apnea		Family
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Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma Blood Clots Blood Disorders Breathing Problems Cataracts Childhood Arthritis Colitis Crohns Cancer	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease Hypertension Irritable Bowel Jaundice Kidney Disease Leukemia Liver Disease/ Hepatitis Low Back Pain	You		Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever Rheumatoid Arthritis Restless Leg Syndrome Sleep Apnea Stomach Ulcers Stroke Thyroid Disease Tuberculosis		Family
Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma Blood Clots Blood Disorders Breathing Problems Cataracts Childhood Arthritis Colitis Crohns Cancer Depression	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease Hypertension Irritable Bowel Jaundice Kidney Disease Leukemia Liver Disease/ Hepatitis	You		Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever Rheumatoid Arthritis Restless Leg Syndrome Sleep Apnea Stomach Ulcers Stroke Thyroid Disease		Family
Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma Blood Clots Blood Disorders Breathing Problems Cataracts Childhood Arthritis Colitis Crohns Cancer	You F		Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease Hypertension Irritable Bowel Jaundice Kidney Disease Leukemia Liver Disease/ Hepatitis Low Back Pain	You		Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever Rheumatoid Arthritis Restless Leg Syndrome Sleep Apnea Stomach Ulcers Stroke Thyroid Disease Tuberculosis		Family
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Anemia Ankylosing Spondylitis Anxiety Arthritis Asthma Blood Clots Blood Disorders Breathing Problems Cataracts Childhood Arthritis Colitis Crohns Cancer Depression Other:		amily	Diabetes Epilepsy/Seizure Fibromyalgia Goiter Gout Hearing Problems Heart Disease Hypertension Irritable Bowel Jaundice Kidney Disease Leukemia Liver Disease/ Hepatitis Low Back Pain	You	Family	Osteoarthritis Osteoporosis Osteoporosis Other Pneumonia Psoriasis Rheumatic Fever Rheumatoid Arthritis Restless Leg Syndrome Sleep Apnea Stomach Ulcers Stroke Thyroid Disease Tuberculosis		Family



ratient Name:
Preferred Pharmacy: Pharmacy Phone:
Present Medications: List all medications and doses, including over the counter medications:
1
4
Medication Allergies: List any medication allergies and associated reactions you have:
Social History:
Do you drink alcohol? If yes, estimate the number of drinks per week:
Have you ever smoked? Current? How many packs per day? How many years?
Have you ever used illegal drugs? If yes, what kind?
Do you exercise regularly? How often and how long?
Last Menstrual Period: Contraception Method: Pregnancies:
Miscarriages/abortions: Current or past use of female hormones? Y/N
With whom do you currently live?Occupation:
Diagnostic/Lab Tests:
MRI Scans CT Scans
Date of last eye exam:/ Date of last chest x-ray:/
Date of last Tuberculosis Test:/ Date of last bone densitometry:/
Most recent labs:/ Where :



Patient Name:

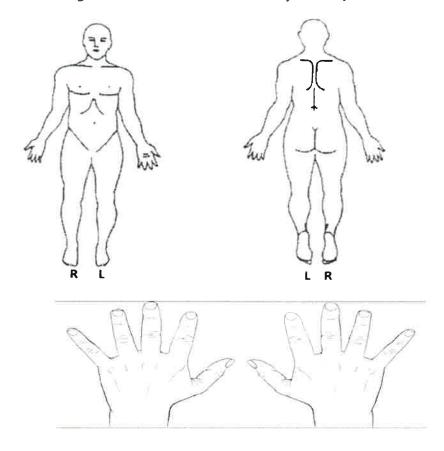
Age of Menopause

GC 		
Are you currently experiencing sym	ptoms in any of the following areas todo	ıy:
SYSTEMIC/HEENT	CARDIOVASCULAR /	HEMA / ENDO/ DERM
Y □ N □ Fatigue	PULMONARY	Y ☐ N ☐ Easy Bruising
1 - N - I augue	Y □ N □ Edema (fluid	Y 🗆 N 🗆 Enlarged Lymph Gland
Y □ N □ Weight Gain	retention)	Y □ N □ Heat Intolerance
C	Y □ N □ Chest pain	Y □ N □ Cold Intolerance
Y □ N □ Weight Loss	Y □ N □ Palpitation	Y □ N □ Rash
Y □ N □ Insomnia	Y ☐ N ☐ Shortness of Breath	Y □ N □ Hair loss
Y □ N □ Dry Eyes	Y □ N □ Cough	
• •	Y □ N □ Wheezing	Musculoskeletal
Y □ N □ Dry Mouth		Y □ N □ Finger/toe color change
Y □ N □ Sores in Mouth		Y □ N □ Fingertip Ulcers
Y □ N □ Severe Snoring		Y □ N □ Neck/Back Pain
TEN E Severe Shoring	NEUROLOGIC / PSYCHIATRIC	Y □ N □ Broken Bones
	Y □ N □ Numbness	Y □ N □ Muscle Aches
<u>GI</u>	Y □ N □ Tingling	Y □ N □ Shoulder Pain
Y □ N □ Heartburn	Y □ N □ Burning Sensation	Y □ N □ Shoulder Swelling
Y □ N □ Abdominal Pain	Y □ N □ Poor balance	Y □ N □ Elbow Pain
V D N D Constinution	Y □ N □ Muscle Weakness	Y □ N □ Elbow Swelling
Y □ N □ Constipation	Y □ N □ Anxiety	Y □ N □ Wrist/Hand Pain
Y □ N □ Diarrhea	Y □ N □ Depression	Y □ N □ Wrist/Hand Swelling
Y □ N □ Rectal Bleeding	Y □ N □ Headache	Y □ N □ Hip Pain
Y □ N □ Nausea		Y □ N □ Hip Swelling
i □ N □ Nausea		Y □ N □ Knee Pain
		Y □ N □ Knee Swelling
GU/GYN		Y □ N □ Ankle/ Foot Pain
Y □ N □ Pain w/urination		Y □ N □ Ankle/Foot Swelling
Y □ N □ Blood in Urine		Y □ N □ Morning Stiffness How long does it last?
Y □ N □ Menstrual Irregularity		-

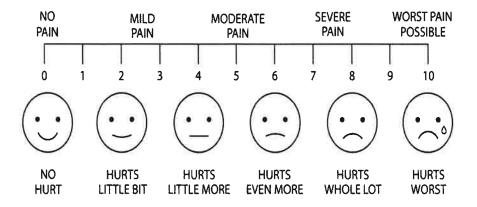


Patient's I	Name:			

On the diagram, shade in the areas where you feel pain



Please circle the amount of pain you are in today.





Office and Financial Policies

Welcome and thank you for choosing Tara Rizvi, M.D. We look forward to serving you and strive to provide you with quality care. Please carefully review the following information and initial by each section:

1. Insurance: When making an appointment with one of our physicians, it is your responsibility to confirm with your
insurance company that the physician is currently under contract with your plan. If your plan requires a referral and you or your
provider does not provide one by the scheduled appointment time, please be prepared to pay for your visit in full or reschedule.
2. Uninsured Patients: If you do not have medical insurance, we will extend cash pay rates to you. These rates are only if
payment is made in full at the time of service.
3. Non-covered Services: I understand the services rendered may not be covered by my health plan. If the insurance plan
determines a service to be "not covered" I will be responsible for the complete charges. If it is later determined that my coverage was
not active on the day of the service, I will be responsible for the complete charges.
4. Returned Check: A service fee of \$35 will be charged to your account for all returned checks which are payable by cash
or credit card. This fee is applied to your account in addition to the original check amount.
5. Day of Visit: Please complete the requested paperwork in full. Please arrive at least 15-30 minutes prior to your scheduled
time. You must present your current insurance card along with a valid picture I.D. to verify your identity. On each follow-up
visit you will be asked to verify demographic and insurance information. All copays/deductibles will be collected at the time of
check-in. Typically, only an office visit charge is covered by your copay and any additional services are subject to your plan's specific
details.
6. Forms: We understand that there may be times when you need a form completed by your physician (i.e. medical leave,
disability). We are willing to assist with these requests but kindly allow us 7-10 business days for completion of these requests. Based
on the amount of information requested, fees will be discussed prior to completion.



7. No show fee and late cancellations: Please call our office promptly if you are unable to keep your appointment. To cancel your scheduled appointment, please call at least 24 hours in advance. A cancellation of a Follow Up visit with less than 24 hours' notice to the office or a Follow Up visit / Testing/ Infusion/ injection visit for which you "no-show" will result in a fee of \$25.00. A New Patient appointment cancellation with less than 24 hours' notice or "no show" will result in a fee of \$50. This fee must be paid before scheduling the next appointment. If three (3) appointments are missed, you will no longer be considered a patient of this practice. After your third missed appointment, as a New Patient, we will contact the referring doctor and let them know. After your third missed appointment as an Established Patient, you will be notified by mail to find another Rheumatologist. We will continue to care for you over the next 30 days for emergencies only. This fee is not covered by insurance. Therefore, it is the sole responsibility of the patient. Please be aware confirmation calls are a courtesy and not the office's responsibility. 8. Medical Records: A medical record release form must be filled out for the release of any medical records. Records released to the patient can be provided for a fee of \$1.00 per page for the first 25 pages and 0.25 cents for each page thereafter. 9. Phone Communication: Any calls will be made to the primary phone number Tara Rizvi, M.D. has on file for you. I hereby authorize Tara Rizvi, M.D. to call my cell/home phone for billing and/or health care matters. 10. Medical Refill Policy: I understand that should I need any refills on my medications, they should be requested during my appointment with the doctor. I also understand that any requests made outside of this time, I must allow 3-5 business days for prescriptions to be filled. I take responsibility to call the office in the appropriate timeframe for my medications to be refilled before I run out. If there is a change in my pharmacy information, I take responsibility to contact the office and give the updated

Insurance Claims:

information.

There is no doubt that health insurance benefits are confusing. Most plans do not provide 100% coverage for medical expenses. Each plan has its own set of rules, exclusions, and benefit structures. It is your responsibility to be familiar with your insurance policy's requirements. If you are unsure of your coverage as it relates to services rendered at our office, you should call the customer service telephone number on your insurance card before receiving services.

Insurance is a contract between you and your insurance company. We will submit a claim to your insurance company as a courtesy to you. To properly file a claim with your insurance company, we require that you disclose all insurance information including primary and secondary insurance, and any change of insurance information at each visit. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including those above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

In the event your claim is denied for a date of service by your insurance company, due to non-payment of health insurance premiums, you will be responsible for payment in full for the services rendered. Proof of premium payment for Exchange products will be requested at time of appointments.



Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive telephone and/or videoconferencing equipment and devices that enable healthcare providers to deliver health care services to patients when located at different sites.

- 1. I understand that the same standard of care applied to a telemedicine visit as applies to an in-person visit.
- 2. I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent will be obtained for anyone else other than my healthcare provider present in the room.
- 3. I understand that there are potential risks to using technology including service interruptions, interception, and technical difficulties. a. If it is determined that the telephone/videoconferencing equipment and/or connection is not adequate, I understand that my health care provider may discontinue the telemedicine visit and make other arrangements to continue the visit.
- 4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care of treatment. a. I may revoke my rights at any time by contacting **Tara Rizvi**, **M.D.** at **346-257-4300**.
- 5. I understand that the laws that protect my privacy and the confidentiality of health care information apply to telemedicine services.
- 6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
 - a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
 - b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
 - c. I understand that my health plan payment policies for telemedicine visits may be different from policies for in-person visits.
- 7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand during my telemedicine visit.

Patient Name	
Signature	
Signature	Date



Patient Electronic/Voicemail/Telephone Communication Consent

Tara Rizvi, M.D. is dedicated to keeping your medical record information confidential. You should be aware that although addressed to your physician, the staff and/or colleagues would have access to this information. When sending emails, please put the subject of your messages so we can process them more efficiently. Also, include your name and return telephone number in the message. We also ask that you acknowledge receipt of emails coming from this office. Communications relating to diagnosis and treatment will be filed in your medical record. I understand that this office will not be responsible for information loss or breaches of confidentiality that are due to factors beyond this office's control.

Please be aware that portal communication, emails, and calls, require staff time and are generally a medical request from the patient that is apart from a traditional office visit, but require the same decision making and time that would be provided in office. A claim will be made to your insurance company for this service. If this is denied by your insurance, or applied to your deductible or coinsurance you will be liable for balance.

Please Initial :
I agree that I will be responsible for all non-covered fees for portal communications, emails and prolonged calls.
I agree to have messages left on my voicemail for appointment, billing, and non-serious health care issues.
I understand and agree to the above electronic communication policy.
Patient's Name: Date:
Signature :



Authorization to Release Medical Records

Please enter full name and date of birth and relationship to the patient for each individual.

Full Name	Date of Birth	Relationship to Patient	Contact Telephone Number	Healthcare, treatment, Billing Issues Please circle all that apply.
				Healthcare
				Treatment
				Billing
				Healthcare
				Treatment
				Billing
				Healthcare
				Treatment
				Billing

*** Please note - This authorization is optional and does not grant access to the patient's medical records. All requests for medical records must be authorized by the patient in writing. This allows our staff to speak to these individuals.

I understand this authorization may be revoked by me at any time and must be done so in writing.

By signing below, I give permission to Tara Rizvi, M.D. to use and disclose PHI necessary to carry out treatment and/or payment. By signing this form, I understand that the privacy practices of the office have been disclosed to me. I agree that Tara Rizvi, M.D. may send medical-related correspondence to me via electronic communication, and that we may respond to your electronic communication to us via electronic communication.

Signature (Patient/Parent/Guardian)

Date

Date of Birth

This authorization is valid from the date signed until revoked by written communication to Tara Rizvi, M.D.



HIPAA NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practice Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (IPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information that may identify you and that related to our past, present and future physical or mental health or condition and related health care services,

TREATMENT

We will use and disclose your protected health information to provide t, coordinate and/ or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we would disclose you protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician who you have been referred to information, ensure that the physician has the necessary information to diagnose and treat you.

PAYMENT

Your protected health information will be used to, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may be required that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS

We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities. Employee review activities, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients ins our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicated your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of appointments. We may use or disclose your protected health information in the following situations without your authorizations.

These situations include: as required by Law, Public Health issues as required by Law, Communicable Diseases, Health Oversight, Abuse and neglect, Food and drug Administrations requirements, Legal Proceedings, Law Enforcements, Coroners, funeral Directors, and Organ Donation, research, Criminal Activity, Military Activity, National Security, when required by the Security of the Department of Health and human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunities object unless required by law. You may revoke this authorization, at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on t the use or disclosure indicated in this authorization.

Following is a statement of your rights with respect to your protected health information: You have the rights to inspect and copy your protected health information. Under the federal law, however, you may not inspect or copay the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

ACKNOWLEDGENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be disclosed.	
understand that I am entitled to receive a copy of this document at my request.	

Patient Name :	Date:
Patient's Signature:	Witness:



Authorization to Release Information:

I authorize **Tara Rizvi, M.D.** to release information to my healthcare insurer, the Center for Medicare and Medicaid Services (CMS), or any other entity necessary to determine benefits and process claims related to medical services that have been provided to me. An electronic copy of this authorization will be deemed as valid as the original.

Assignment of Benefits:

I authorize payment of insurance benefits, including CMS benefits, for medical services provided to me directly to **Tara Rizvi**, **M.D**. An electronic copy of this authorization will be deemed as valid as the original.

Financial Responsibility:

I have read the **Tara Rizvi**, **M.D.** Financial Policy and understand that I am responsible for all fees for medical services rendered to me by the physician , Physician Assistant and nurses of **Tara Rizvi**, **M.D**. Any fees deemed patient responsibility or are not covered by my insurance company will be due on the day of service or upon resolution of my insurance claim. **Tara Rizvi**, **M.D**. reserves the right to request payment of these fees before my insurance company has completed the processing of my claim (s) or if my claims are denied. It is my responsibility to notify Tara Rizvi, M.D. of any changes in my health care coverage before services are rendered. I understand that by signing this form that I am accepting financial responsibility as explained above for payment for medical services rendered to me. An electronic copy of this authorization will be deemed as valid as the original.

Patient Name :	Date :	
Patient Signature:		
Witness:		

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? (Use "\sum " to indicate your answer)		Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things		0	11	2	3
2. Feeling down, depressed, or hopeless		0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much			1	2	3
4. Feeling tired or having little energy		0	1	2	3
5. Poor appetite or overeating			1	2	3
Feeling bad about yourself — or that you are a failure or have let yourself or your family down		0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television		0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual		0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way		0	1	2	3
	For office co	DING <u>0</u> +		· +	
			=	Total Score	· ·
	oblems, how <u>difficult</u> have these at home, or get along with other		nade it for	you to do	your
Not difficult at all	Somewhat difficult	Very difficult □		Extreme difficu	-

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name			
D.O.B			
Address:	Telephone		
City	State	Zip Code	
I authorize			
To release any and all information	on of the patient named	above to:	
	Dr. Tara J. R 23920 Katy Freeway Katy, TX 77- 346-257-4300 F 832-437-8650	Suite 440 494 Phone	
limited to progress notes, lab rep	orts, radiological repo	ecords and documents including but not rts, histories and physicals, immunizations, other medical documents currently in your	
testing, diagnosis, and/or treatm	ent from HIV (AIDS v. lth, or drugs and/or alc	ease any health care information relating to irus), sexually transmitted diseases, ohol use, you are specifically authorized to s, testing, or treatment.	
Signature of Patient:		Date:	