RELEASE OF MEDICAL INFORMATION AUTHORIZATION:

I give **Lone Star Neurology** authorization for the release of "Medical Records/Privacy Information", which includes your PHI, any medical conditions and/or billing and financial information to the following:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I am issuing this letter for granting access to any of my medical records, like all X-rays, CT scans, MRI scans and other information relating to my treatment which I am undergoing at Lone Star Neurology under the care and treatment of Maushmi Sheth, M.D., Ramin Ansari, M.D., Sandeep Dhanyamraju, M.D., Yu Zhao, M.D., Satish Gaddam, M.D., Riaz Tadia, M.D., John Harney, M.D. or Mahmood Akhavi, M.D. However, I notify that this disclosure of my personal medical information should not be for any other purpose other than this.

_____

Full Name of Patient

_____

Signature of Patient

_____

Date