Pear Tree Medical Associates

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Office: 281-412-6700
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Patient Name (please print): ______________________________________

Date of Birth: ____________Other Names Used: ____________________

Phone Number (where you can be reached): __________________________

I authorize the release of my medical records:

From: Isabelle Jeffress, MD, 6302 Broadway, Suite 130, Pearland, Texas 77581

To: (check which applies)

□ MHMG Central Pearland, 3203 E Broadway St #100, Pearland, TX 77581

□ Change PCP (Please Provide Name, Address, Phone and Fax):

Please send at least the past 2 years of clinical notes and lab reports, and the past 5 years of x-rays, diagnostic tests, and operative reports.

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I understand that:

- The purpose of this release is for on-going medical care.
- The recipient of these records cannot transfer them to another party without consent from me (or authorized representative), except for purposes of treatment, payment or operations.
- This authorization will expire in 60 days and can be revoked in writing at any time.
- General medical records sometimes contain reference to drug use, alcohol use, rehabilitation treatment, psychiatrictreatment, sexual abuse, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and other sensitive issues. I agree to release these records.
- A photocopy or fax of this authorization is as valid as the original.

I agree to release these records. I have read this release and any questions or concerns of mine have been answered.

__________________________________ __________

Signature of Patient or Authorized Representative Today's Date

Please return a copy of this patient authorization with records