MEDICAL RECORDS REQUEST FORM
<u>New Patients</u> (signature only unless forwarding to other Providers)

Abigail Neiman M.D., P.A.
902 Frostwood Drive, Suite # 311
Houston, TX 77024
Phone: 713-932-0054
Fax: 713-932-0413

This authorizes you_____**(Name of physician or medical facility), Phone:**_____**Fax:**_____ to provide a copy, summary, or narrative of my medical records (as indicated by the check mark below) or otherwise release confidential information.

____ Complete record
____ Records of care from the following dates_____to _____
____ Records concerning the following conditions:_____
____ Other, please specify: _____

Patient Name: _____

SSN:_____ **DOB:**_____

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 record.

Initials: _____Date:_____

Release to the following person:
Abigail Neiman M.D., P.A.
902 Frostwood Drive, Suite # 311
Houston, TX 77024

Patient Signature_____Date:_____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Texas State Board of Medical Examiners.