Release of Medical Records

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3070 College Street #205
Beaumont, Texas 77701
Tel: 409-833-1225
Fax: 409-833-0927

To: ____

City: ___________________________ State **:** _______ **Zip:** _______

I authorize the release the medical records of my child/ children named below to:

Raja H. Ataya M.D., F.A.A.P.
3070 College Street #205
Beaumont, Texas 77701
Tel: 409-832-1225
Fax: 409-832-0927

Child 1

Name: _____________________________

D.O.B.: ____________________________

Child 2

Name: _____________________________

D.O.B.: ____________________________

Child 3

Name: _____________________________

D.O.B.: ____

Child 4

Name: ____

D.O.B.: ____