



**NEWMAN
TAUB & CHU**
E Y E C E N T E R

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize _____

to furnish full details of the medical care and treatment:

patient's name: _____

S.S.# _____

D.O.B. _____

To: Gordon H. Newman, M.D./Larry R. Taub, M.D./Claire Y. Chu, M.D.
5744 LBJ Freeway, Suite 150 1708 Coit Rd., Ste. 240
Dallas, Texas 75240 Plano, TX 75075
(972)392-2020 fax (972)392-4054 (972) 312-9312 fax (972) 312-9369

Patient
signature _____

Witness _____

Relationship to patient _____

Please
include: _____
