NUVEAU Medical Aesthetics
546 Waugh Dr.
Houston, TX 77008
www.nuveaumedspa.com

Authorization to Release Medical Information

Christine S. Cheng, M.D.

Patient Name _____ Date of Birth _____

This letter will authorize Nuveau Medical Aesthetics, LLC to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark below).

___Clinical records of diagnostic and/or laboratory studies

Records of care from dates_____to_____only

___Records of care concerning the following condition(s)

_____

_____

These records should be sent to the following physician:

Name _____

Address _____

City _____ State Zip Code_____

Telephone _____ Fax _____

The purpose for this release of record information is for continuation of care.

I understand that this information will be sent to the above physician within thirty days.

_____

Patient Signature Date

_____

Patient Guardian Signature Relationship Date