

Date:

To:

To Whom It May Concern:

I, \_\_\_\_\_, authorize the release of my medical records as indicated below to Barry A. Nelms, M.D., P.A.

\_\_\_\_\_ FAX: (713) 795-9701

\_\_\_\_\_ MAIL: Barry A. Nelms M.D. P.A.; 5420 West Loop South,  
Suite 2400; Bellaire, TX 77401

\_\_\_\_\_ All Medical Records

\_\_\_\_\_ MRI Reports

\_\_\_\_\_ Operative Reports

\_\_\_\_\_ Other (including, but not limited to, x-rays reports, lab results,  
physical therapy progress notes, etc.)

Your cooperation is appreciated.

Thank You,