MRZ MEDICAL GROUP

ACKNOLWLEDGEMENT

☐ BAYTOWN ☐ KATY

☐ SHANANDOAH ☐ SOUTH WEST

EXAMINEE:_____ DATE:_____

PHYSICIAN:_____

I am aware that the above named physician, has been requested to evaluate me medically at the above facility for the purpose of consultative exam only. I fully understand that the above named physician is not my treating physician or personal physician and that the doctor/patient relationship does not exist nor will be established at this time. I am also aware that the purpose of this evaluation of me is not for the purpose of treatment and that I am only to be evaluated for my present condition as submitted to this office by the Division of Disability Determination Services. In submitting to an examination with the above named physician, I am not relying on any determination of diagnosis or treatment as explained above. I fully acknowledge that the responsibility for my health is shared by me and my treating physician and not the above named physician.

EXAMINEE PRINTED NAME:_____

EXAMINEE SIGNATURE:_____ DATE:_____

FARZANA SAHI
7777 SOUTHWEST FRWY, STE. 640
HOUSTON, TX 77074

MEDICATION SHEET

PATIENT NAME:

_____

MEDICATION	DOSE	FREQUENCY