5413 CRENSHAW RD, SUITE 400 PASADENA TX, 77505
Phone (713)943-2800 Fax(713)943-2801

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the release of any information including diagnosis and records of any treatment, examination, or surgery rendered to me during the period of _____to_____ to be sent to the doctor below:

Dr. Name:_____

Address:_____

Telephone #:_____

Fax #: _____

Patient Name:_____

D.O.B: _____

Signature: _____

Witness: _____