

**Authorization for Release of
Medical/Dental Records**

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PHONE: (281) 239-3900
FAX: (281) 239-3848



Patient's Name

Date

I hereby request and authorize the release of all information, without limitations, regarding any physical and mental condition, as revealed by your observation or treatment, past, present or future.

This includes photocopies of medical and/or dental histories, x-ray findings, diagnosis, treatment, prognosis and financial records.

I request that you release the above information to:

(Fill in name of receiving doctor/clinic/person/company)

Address

City

State

Zip

Patient's (or Legal Guardian's) Signature

Date

Witness' Signature

Date