The Skin Surgery Center of Houston

915 Gessner Road, Suite 640
Houston, TX 77024
713.984.0010 (phone)
713.984.0067 (fax)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: ____
(First) (MI) (Last)

Date of Birth: ____________________ Social Security #: ___________________________

I hereby authorize the release of my photocopied records (Office Visit Notes, Pathology Reports, Labs Results/Blood Work) and request that they be transferred **FROM**:

The Skin Surgery Center of Houston
915 Gessner Road, Suite 640
Houston, TX 77024

I hereby authorize the release of my photocopied records (Office Visit Notes, Pathology Reports, Labs Results/Blood Work) and request that they be transferred **TO**:

Physician/Clinic or Name of Person:
____

Address: ____

City: ___________________________________ State ____________________ Zip_______________

Fax: ____ Telephone: _________________________

Authorization to release medical records via fax, mail, or pick up: _____Yes ____No

Patient/Guardian Signature: ____________________Printed Name________________Date: ____
Witness Signature: ___________________________ Printed Name________________Date: ____