**HOUSTON MEDICAL**

**WELLNESS CLINIC**

5910 Fairdale Lane, Houston, TX 77057

Phone: (713) 781-1905 / Fax: (713) 583-2992

[www. Houston](http://www.Houston) Medical Wellness Clinic.com

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient’s Name: Date of Birth:

Previous Name: Social Security #:

I request and authorize to release my healthcare information / medical records to be used for further assistance in my medical care, to:

Clinic: Houston Medical Wellness Clinic

Address: 5910 Fairdale Lane

City: Houston State: TX Zip Code: 77057

This request and authorization applies to:

Healthcare information including the treatment, condition, and/or dates related to:

Carpal Tunnel

All healthcare information

Other:

Credit card on file? Yes No

I authorize the release of any records regarding treatment received by the above referenced patient.

Patient Signature (or responsible party if patient is a minor) Date Signed

**THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED**