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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:**

Bradley I. Beckman, M.D.
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 or Clinic Name: _____

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: _____