



Brenda R. Hassebrock
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

ATTN: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE THE MEDICAL RECORDS FOR THE FOLLOWING PATIENTS:

PATIENT NAME: _____

D.O.B. ____/____/____ SOCIAL SECURITY # _____

PHONE NUMBER: _____

PLEASE FAX THE FOLLOWING RECORDS

- | | |
|--|--|
| <input type="checkbox"/> ALL RECORDS | <input type="checkbox"/> DISCHARGE SUMMARY |
| <input type="checkbox"/> HISTORY & PHYSICAL EXAM | <input type="checkbox"/> MRI OF _____ |
| <input type="checkbox"/> PROGRESS NOTES | <input type="checkbox"/> CONSULTATION REPORTS |
| <input type="checkbox"/> RADIOLOGY REPORTS | <input type="checkbox"/> HIV TEST RESULTS |
| <input type="checkbox"/> RADIOLOGY FILMS | <input type="checkbox"/> PSYCHIATRIC RECORDS |
| <input type="checkbox"/> LABORATORY REPORTS | <input type="checkbox"/> DRUG SCREEN, BLOOD, ALCOHOL |
| <input type="checkbox"/> OTHER _____ | |

TO: HEALTHSOURCE
DR. BRENDA HASSEBROCK, D.C.
Fax: 713-780-8378

X _____
Signature of Patient

Date: ____/____/____

_____ Please Print Name

_____ Signature of Legal Guardian

Date: ____/____/____

_____ Please Print Name

