



MEDICAL RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

This Form intended as a Release of healthcare Information to:

Houston Fibroids

FAX: 713-575-3688

☐ I _____ (please print clearly) request and authorize the release of Healthcare Information including the diagnosis, records; physical examination, diagnostic imaging, labs and treatment plan rendered to me.

Should you have any questions, Please call my: ☐ my home ☐ my work ☐ my cell
Number: _____ Alternate number: _____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ The best time to reach me is (day) _____ between (time) _____

Patient signature:

Date: ____/____/____ Time: _____AM/PM

Special Instructions/Request:

