H A R P E R

Wellness & Rehab Center

RECORDS RELEASE AUTHORIZATION FROM HWR

Date:_____

RE Patient Name:_____

Patient DOB:_____

I hereby authorize Harper Wellness & Rehab Center to release my medical records and x-rays / reports to:

_____

_____

_____

_____

_____ _____

Patient Signature Date

_____

Witness

I understand that these original x-rays are released with the understanding that they are the legal record of the office of Dr. Dana Harper and therefore the property of Dr. Dana Harper. The x-rays are solely for the use of a licensed physician to facilitate treatment and diagnosis. If they are transferred to another physician, the office of Dr. Dana Harper must be notified in writing.

Total # of views:_____

Views enclosed: Cervical _____ Thoracic _____ Lumbar_____ Other_____

4544 Post Oak Place Drive, Suite 287, Houston, TX 77027

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