H A R P E R

Wellness & Rehab Center

MEDICAL RECORDS RELEASE AUTHORIZATION TO HWR

Date:_____

To:_____

_____

_____

Phone:_____ **Fax:**_____

RE: Patient Name:_____ **DOB:**_____

To Whom It May Concern:

I hereby authorize you to release my medical records including any and all diagnostic and radiological reports to:

HARPER WELLNESS & REHAB
4544 Post Oak Place Drive, Suite 287
Houston, TX 77027
Phone: (713) 622-3456 Fax: (713)622-6408

Specifically, please send the following:

_____ Initial medical history, physical examination and progress notes and any other reports you may think are important to the care of this patient. (EX: MRI, EMG, Spionscope)

_____ Previous X-Rays and radiological finding reports

My next appointment with Dr. Harper is on _____ and I would appreciate my records being forwarded as soon as possible.

Thank you for your assistance.

Patient Signature:_____ Date:_____

Witness:_____ Date:_____