Wilson Hand Surgery,PLLC

6560 Fannin Street
Scurlock Tower, Ste 1810
Houston, TX. 77030

Phone: 832-530-4081 Fax: 877-497-3616

AUTHORIZATION TO RELEASE CLINICAL INFORMATION

I, _____, authorize the named healthcare provider _____

to release clinical information and/or records to the specified provider.

PROVIDER: WILSON HAND SURGERY, PLLC DR. BARBARA WILSON 6560 FANNIN ST. SUITE 1810 HOUSTON, TX 77030	**PATIENT:** **LAST 4 OF SSN:** **DOB:** **PHONE #:**

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ CLINICAL DOCUMENTS (H/P, DISCHARGE SUMMARY, OP- NOTE, CONSULTS)
- ☐ LAB REPORTS
- ☐ RADIOLOGICAL IMAGES AND REPORTS
- ☐ ALL OF THE ABOVE

THE AUTHORIZAED RECORDS WILL BE USED FOR:

- ☐ PHYSICIAN REQUESTED
- ☐ PERSONAL
- ☐ LEGAL REPRESENTATION
- ☐ OTHER: _____

This authorization will expire one year from the date listed below. I understand that I can revoke this authorization at any time by writing to Wilson Hand Surgery, PLLC. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I also understand that I am not required to sign this authorization and that my health care or payment for will not be affected by my refusal. Federal privace regulations will no longer apply to the information disclosed. A copy of this authorization may be utilized with the same effectiveness as the original.

PATIENT SIGNATURE: _____ DATE: _____

PERSONAL REPRESENTATIVE NAME: _____RELATIONSHIP TO PATIENT: _____