HAIR AND SKIN
SCIENCE CENTER

5373 W. Alabama, Suite # 204
Houston, TX 77056
admin@hasscenter.com
Phone: (281) 607-7739
Fax: (281) 299-0091

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I, the undersigned hereby authorize:

Doctor/Office:	
Address:	
Phone:	**Fax:**

To release the information specified below:

[ ] Office Visit Notes

[ ] Billing Records

[ ] Pathology Reports

[ ] Laboratory Report

TO:

Hair and Skin Science Center
5373 W. Alabama, Suite # 204
Houston, TX 77056
admin@hasscenter.com
Phone: (281) 607-7739
Fax: (281) 299-0091

I understand that this authorization will expire in 90 days from the date of signature. I also understand this information may contain sensitive information about my health (STDs, HIV/AIDS, etc). This authorization may be cancelled at any time when the provider receives my notice in writing.

Patient Signature:	Date:
Print Name	DOB: