AUTHORIZATION TO RELEASE MEDICAL RECORDS

HAIR AND SKIN SCIENCE CENTER

I, the undersigned hereby authorize:

Doctor/Office: Kudakwashe Maloney, MD / Hair and Skin Science Center	
Address: 5373 W. Alabama, Suite 204_Houston, TX 77056	
Phone: (281) 607-7739	**Fax:** (281) 299-0091

To release the information specified below:

[ ] Office Visit Notes

[ ] Billing Records

[ ] Pathology Reports

[ ] Laboratory Report

TO:

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

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: