

Libbyette E. Wright, M.D.

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: \_\_\_\_\_  
(First) (MI) (Last)

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I hereby authorize the release of my photocopied records (Office Visit Notes, Pathology Reports, Labs Results/Blood Work) and request that they be transferred **FROM:**

Libbyette E. Wright, M.D.  
915 Gessner Road, Suite 640  
Houston, TX 77024

I hereby authorize the release of my photocopied records (Office Visit Notes, Pathology Reports, Labs Results/Blood Work) and request that they be transferred **TO:**

Physician or Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Fax: \_\_\_\_\_ Telephone: \_\_\_\_\_

Authorization to release medical records via fax, mail, or pick up: \_\_\_\_ Yes \_\_\_\_ No

Patient/Guardian Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Printed Name \_\_\_\_\_ Date: \_\_\_\_\_