

# HCA Houston Healthcare Southeast

## MULTI-SPECIALTY CLINIC

### RELEASE OF MEDICAL INFORMATION

I, \_\_\_\_\_ DOB \_\_\_\_\_

Authorize the only persons listed below to have access to my confidential medical records, and information:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date