

Terry A. Clyburn, M.D.

5420 West Loop South Suite 2400, Bellaire, TX 77401

Phone: 713-357-4752 Fax: 832-213-0308

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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

First Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Name : \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
Release healthcare information of the patient named above to:

Name: Terry A. Clyburn M.D.

Address: 5420 West Loop South Suite 2400

City: Bellaire State: TX Zip Code: 77401

This request and authorization applies to:

- All healthcare information including x-rays and diagnostic test results

Patient Signature : \_\_\_\_\_ Date Signed: \_\_\_\_\_

This authorization expires ninety days after it is signed