Authorization for Release of Protected Medical Information

Patient Name:

Date of Birth:

Patient's Address:

Phone Number:

I authorize

Eric K. Tondera, NP-C, DC
Tondera Family Practice and Chiropractic
1201 Dairy Ashford, Suite 118
Houston, Texas 77079
713-988-3223 (Phone)
832-617-7823 (Fax)

To release any information/records pertaining to my health to the following:

Name: _____

Address: _____

Relation: _____

Phone Number: _____

Fax Number: _____

Thank you for your assistance.

Sincerely,

_____
Signature of Patient

_____
Date