# WILSON IMAGING CENTERS

## Release of Records

**TRACING** **Date of Birth:**

**(if Minor, Name of Responsible Party_____**

**I authorize the release of medical and or dental records taken on:**

**DATE**
**Referred by Dr.**

**To the Following**

**_____**

**_____**

**_____**

**Patient or Legal Guardian**

**Signature_____**

**Date_____**

**Referring Doctor**

**Signature_____**

**Date_____**

**PLEASE FAX TO 713 271-0202**