AIM Center
for Health and Wellness
promoting the health and well-being of our patients

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Previous Name: _____

Date of Birth: _____ Social Security #: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Address: AIM Center for Health and Wellness
1411 N. Beckley Ave.
Pavilion III, Suite 352
Dallas, Texas 75203

Phone: (214) 943-2249
Fax: (214) 943-8213

This request is for:

- ☐ Howard Anderson Jr., M.D.
- ☐ Mollie Dorrough, M.D.
- ☐ Kimberly Johnson, D.O.
- ☐ Keira Scanks, M.D.

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:
  _____
  _____
- ☐ All healthcare information
- ☐ Other: _____
  _____

Please send all requested information to the address or fax number listed above.

Patient's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.
Thank you for your prompt attention.