Medical Record Release Form

By signing this form, I authorize _____ to release confidential health information about me, by releasing a copy of my medical records, or a summary/narrative of my protected health information to the physician/facility/entity listed below.

Patient Name: _____ DOB: _____

The information authorized to release is as follows:

☐ Complete Records
☐ Treatment Plan
☐ Pathology Reports
☐ Radiology Reports
☐ Laboratory Results
☐ Progress Notes
☐ Medication History
☐ Hospital Reports
☐ Operative Reports
☐ Other: _____

Release the above-mentioned records to the following physician/facility/entity:

☐ Arthritis & Osteoporosis Center of South Texas
14615 San Pedro Ave, Suite 105
San Antonio, TX 78232
Ph: 210-404-0020
Fax: 210-404-0325

☐ Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Ph: _____ Fax: _____

Conditions and Notifications

This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing Arthritis & Osteoporosis Center of South Texas at the address above. I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

_____ _____
Patient Signature (or patient representative) Date

_____ _____
Patient Print Name (or patient representative) Representative's Authority to Sign for Patient (i.e. parent, guardian, POA, Executer)