Authorization to Obtain Medical Records

I authorize the following Physician's Office/Institution to release Medical Information on the patient listed below:

Patient Name **DOB** **Social Security #**

Previous Physician/ Institution Name
Phone #
Fax #

To release health information to:

Deerwood Family Practice, PLLC
4358 Lockhill Selma Rd, Blding 1, Suite 110
San Antonio, TX 78249
FAX # 210-492-4380

- ☐ Entire Record
- ☐ Radiology Reports
- ☐ Office Notes
- ☐ Immunization record
- ☐ Lab results
- ☐ Alcohol/substance abuse
- ☐ HIV/STD record
- ☐ Mental Health
- ☐ Billing

X

Patient/Legal Guardian Date