Request of Medical Records

I _____, DOB _____, SS# _____ - _____ - _____
(Patient Printed Name)

hereby authorize,

Dr. _____ located at:

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To release my confidential medical records to:

Physician Care Centers
2829 Babcock Rd, Ste.117 San Antonio, Texas 78229
Phone: (210) 341-9614 Fax: (210) 340-5924

I authorize the selected information to be sent: (Please check all that apply)

_____ **All Below** (this will include all that was done in clinic)
_____ Treatment and prognosis of any physical or mental condition
_____ Psychiatric history or treatment
_____ Drug or alcohol abuse history or treatment
_____ Infectious or contagious disease information including HIV/AIDS
_____ Living Will
_____ Durable Power of Attorney of Healthcare
_____ Immunization records
_____ Billing Statements

Purpose of Records Release: _____

I agree that copies of this authorization may be used in place of the original. I also understand that this consent shall automatically expire ninety (90) days from the date set forth below.

(Patient's Name Printed) _____Signed this _____ day of _____, 20____.

(Patient's Signature) _____Signed this _____ day of _____, 20___.