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REQUEST FOR RELEASE OF MEDICAL RECORDS OR HEALTH INFORMATION

DATE: _____

I hereby request and authorize:

Telephone: _____

Fax: _____

The release and disclosure of my protected health information including office records, consultations, progress notes, history and physical examinations, inpatient admissions, hospital discharge summaries, laboratory test results, x-ray reports, pathology reports, operative reports, medication administration records, physician orders, physical therapy as follows: (Check all that apply)

- Complete Medical Record for all services
- Hospital and ER records related to the following date(s) of service: _____
- HIV Test Results

PATIENT NAME: _____

DATE OF BIRTH: _____ **SS#:** _____

TO: Suzanne K. Gazda, MD **ATTN:** _____

Your prompt attention to this request will be appreciated.

Fax reply can be received 24 hours a day, every day of the week on a secured fax at (210) 615-8718.

 Patient (or guardian) signature

 Date