PERINATAL ASSOCIATES
OF SAN ANTONIO

502 Madison Oak Ste. 210 San Antonio, TX 78258
7707 Ewing Halsell Ste. 234 San Antonio, TX 78229

Authorization to Release Medical Records

Patient Name: _____

Address:_____

Date of Birth:_____ Last 4 Social Security #: _____

I authorize the release of the following specific medical information from:

Perinatal Associates of San Antonio

☐ 502 Madison Oak Ste. 210
San Antonio, TX 78258
(P) 210-481-3000
(F) 210-481-3222

☐ 7707 Ewing Halsell Ste. 234
San Antonio, TX 78229
(P) 210-614-3000
(F) 210-614-3001

Please release the following:

☐ All Records

☐ Specify what records: _____

Date Range: _____

I request this information be released to:

Name:_____ Organization:_____

Address:_____

Phone:_____ Fax:_____

This is information is to be released for: _____

(disability insurance, life insurance, work release, care coordination, etc.)

If you are requesting a copy these records for yourself, there is a charge of $50.00. Please let us know how you would like your records: Pick Up _____ Mailed_____

I recognize that disclosed protected information may be subject to re-disclosure and therefore may become non-protected information. This authorization expires 180 days from the date signed below and may be revoked in writing at any time.

_____ _____

Patient Signature Date

_____ _____

Patient's Printed Name Phone Number