

SAN ANTONIO METROPOLITAN HEALTH DISTRICT
332 W. COMMERCE
SAN ANTONIO, TEXAS 78205
(210) 207-8730

Authorization for Release of Medical Records

I hereby authorize _____ to release the information specified below
relative to the following period of service _____ on
(month/year of treatment)

Name: _____ DOB: _____ SSN _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Medical Record Number/Patient ID number _____

TO: Agency/Organization /Name _____

Address: _____

For the purpose of _____

The following information is to be released:

- Immunization records History & Physical Lab reports Referrals Dental Records
- Treatments and medications Nurses Notes X-ray Reports Ultrasound reports
- Consultation Reports Other (specify) _____

I understand that upon release of the designated information above, this information may be subject to redisclosure by the recipient. This authorization is subject to revocation at any time except to the extent that action has been taken. This authorization is valid for 3 years.

Signature: _____ Relationship to client _____

Witness: _____ Date: _____

Patient's or Authorized Person's Signature

I hereby authorize the San Antonio Metropolitan Health District to release any medical or other information necessary to process this claim to the designated Health Maintenance Organization and the Texas Department of State Health Services (DSHS). I also request payment of benefits for services to the San Antonio Metropolitan Health District.

Signature _____ Date: _____

Relationship to patient (if other than patient's signature) _____