San Antonio
Foot & Ankle Center

Medical Records Release Form

Patient Name: _______________________________ Patient DOB: _________________________

Dear Doctor and Staff:

Please release my medical records related to treatment for medical conditions rendered by you or under your supervision. This information will be used to further assist in my medical treatment and should be faxed to **210-314-1771** or mailed to

San Antonio Foot and Ankle Center

11212 State Hwy 151 Plaza 1 suite 370

San Antonio, TX 78023

Phone: 210-664-4700

The information you may release subject to this signed release form is as follows:

- Complete Records
- Progress Notes
- Care Plan
- Lab Report
- Medication Record
- Hospital Report
- Pathology Report
- History and Physical
- Operative Report

___________________________ ___________________________ ______________________

Signature Print Name Date

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed above.