Request for Release and Disclosure of Patient Information

I hereby request and authorize the office of __________________to release copies of my medical records to Sonterra Dermatology, PLLC (**Fax Number**): ____(210) 496-7601_____

Sonterra Dermatology, PLLC

1314 E. Sonterra Blvd. Ste. 2201 * San Antonio, TX 78258 * P: (210) 496-5792 | F: (210) 496-7601
2632 Broadway St. * North Building, Suite 201N * San Antonio, TX 78215 * P: (210) 226-0040 | F: (210) 226-0050
www.sonterradermatology.com

This authorization applies to all the reports checked below:

_____ Complete Chart

_____ History and Physical Examinations

_____ Progress Notes and Care Plans

_____ X-Ray Reports

_____ Laboratory Reports

_____ Other: ________________________

Purpose of disclosure: (check all that apply)

_____ Medical Care _____Transfer Records _____Other

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF YOUR SIGNITURE BELOW.

____
Name of Patient or Personal Representative (**please print**)

____
Description of Personal Representative's Authority

____
Signature of Patient or Personal Representative

____
Patient's Date of Birth

____
Date