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

Annabelle L. Garcia, M.D. • Allison Metzinger, M.D. • Milton Moore, M.D.
Tessa Cervantes, M.D. • James Neiner, M.D. • Justin Bandino, M.D.
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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
☐ X-Ray Reports
☐ History and Physical Examinations
☐ Laboratory Reports
☐ Progress Notes and Care Plans
☐ 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 SIGNATURE 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