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## Record Release Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

I, \_\_\_\_\_, authorize  
San Antonio Hand to Shoulder/Dr. Mark Katz to:

Release my medical records to:

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

What information can be disclosed?:

All available records  Office notes  Other: \_\_\_\_\_

This authorization covers the patient's care from \_\_\_\_\_ to \_\_\_\_\_

Purpose of disclosure:  Continuing medical care/treatment  Personal use  Attorney/legal  Insurance

School  Employment  Disability determination

Other: \_\_\_\_\_

This authorization shall be valid for 180 days from the date of signature or as specified on this date (optional)  
month \_\_\_\_\_ day \_\_\_\_\_ and year \_\_\_\_\_.

The patient can revoke this authorization in writing at any time prior to the expiration date.

X \_\_\_\_\_  
Patient's signature or legally authorized representative  
Parent or legal guardian if patient is a minor

\_\_\_\_\_  
Date

X \_\_\_\_\_  
(If applicable) Printed name of legally authorized representative/guardian