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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 Date
Parent or legal guardian if patient is a minor

X_____
(If applicable) Printed name of legally authorized representative/guardian