P.M.A.

Request of medical records

I _____, DOB _____, SS# __ __ __ - __ __ - __ __ __ __
(Patient Name)

hereby authorize,

Dr. _____ Phone: (_ _ _) _ _ _-_ _ _ _ Fax: (_ _ _) _ _ _-_ _ _ _

Address:_____

City:_____ State:_____ Zip Code:_____

To release my confidential medical records to:

Porter Medical Associates
5825 Callaghan Rd, Ste.203 San Antonio, Texas 78228
P: (210) 341-9614 F: (210) 340-5924

I authorize the selected information to be sent: (Please check all that apply)

_____ **All Below** (this will include all that was done in clinic)
_____ Treatment and prognosis of any physical or mental condition
_____ Psychiatric history or treatment
_____ Drug or alcohol abuse history or treatment
_____ Infectious or contagious disease information including HIV/AIDS
_____ Living Will
_____ Durable Power of Attorney of Healthcare
_____ Immunization records
_____ Billing Statements

Purpose of Records Release: _____

I agree that copies of this authorization may be used in place of the original. I also understand that this consent shall automatically expire ninety (90) days from the date set forth below

(Patient's Name Printed)_____Signed this _____ day of _____, 20____.

(Patient's Signature)_____Signed this _____ day of _____, 20____.