



Porter Medical Associates

Authorization for release of information

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

hereby authorize,

Dr. _____ located at:

Address: _____

City: _____ State: _____ Zip Code: _____

To release my confidential medical records to:

Porter Medical Associates
2829 Babcock Rd Suite 117 San Antonio, Texas 78229
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

(Signature) _____ Signed this _____ day of _____, 20____.

(Signature if Minor Patient) _____ Signed this _____ day of _____, 20____.

2829 Babcock Rd | Suite 117 | San Antonio, Texas | 78229 | Ph. 210-341-9614 | Fax. 210-340-5924
2318 Pat Booker Rd | Universal City, Texas | 78148 | Ph. 210-341-9614 | Fax. 210-340-5924
1200 Brooklyn Ave | Suite 220 | San Antonio, Texas | 78212 | Ph. 210-341-9614 | Fax. 210-340-5924
10423 State Hwy 151 | Suite 101 | San Antonio, Texas | 78251 | Ph. 210-341-9614 | Fax. 210-340-5924
2020 Sundance Pkwy | Suite A2 | New Braunfels, Texas | 78130 | Ph. 830-387-2110 | Fax. 830-609-9918