VILLAGE CROSSING
WOMEN'S HEALTH
Live Here. Live Well.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print):

Name:_____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____
_____
_____

Tel: _____ Fax:_____

TO

Village Crossing Women's Health
Dr. Glen Feinstein MD
1139 E. Sonterra Blvd., Ste 260
San Antonio, Tx 78258
210-404-2800 ** Fax 210-404-2803

Medical records requested: _____

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS; this authorization may be revoked in writing at any time and any information disclosed may be subject to redisclosure by the recipient. This authorization expires one (1) year from the date signed.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Date