****

**Records Release Form**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attention (To): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Doctor or Hospital)*

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REQUEST THAT ALL MY RECORDS BE SENT TO THE FOLLOWING PHYSICIAN*

Dr. Rene Perez Dr. Jennifer Arzola Dr. Shawna Wall

Dr. Carlos E. Quezada Dr. Jennifer Chiles Dr. Jeni Vela

CNM Cathy O’Brien CNM Laura Alberg WHNP Carla Barba

*I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY RECORDS TO:*

Alamo Women’s Health OBGYN

3903 Wiseman Blvd, Suite 300

San Antonio, Texas 78251

Clinic: (210) 426-3663

Fax: (210)426-3660

www.alamowomenshealth.com

*PLEASE INCLUDE THE COMPLETE MEDICAL RECORDS IN YOUR*

*POSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING*

*THE PERIOD OF TIME FROM \_\_\_\_\_\_\_\_\_\_\_\_ TO \_\_\_\_\_\_\_\_\_\_\_\_\_ .*

**Patient Information:**

**Name of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have any question please call us at 210-426-3663

Thank you for your prompt attention in this matter.