



Afton Oaks Bldg. I & II - 400 N. Loop 1604 E., Suite 175, San Antonio, TX 78232
(210) 545-4422 ph (210) 545-4495 fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)

Name: _____ Date of Birth: _____

Any Previous Names: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

TEL: _____

FAX: _____

To: Jan Tilley & Associates
400 N. Loop 1604 E. Ste 175
San Antonio, TX 78232
Fax: 210-545-4495

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results, diagnostic tests, and a list of currently prescribed medications.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____

HIPAA: I have read and have access to the HIPAA (Health Insurance Portability and Accountability Act) policies.

Signature: _____ Date: _____