

## RECORDS RELEASE REQUEST

Patient Name: \_\_\_\_\_  
(Please Print)

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

I hereby request release of all of my medical records including communicable disease information such as hepatitis or AIDS/HIV test results; and other physician records that are part of my medical records.

TO: San Antonio Kidney Disease Physicians Group, P.L.L.C

ATTN: Dr. \_\_\_\_\_

1222 McCullough

San Antonio, TX 78212

Phone #: (210) 228-0743

Fax #: (210) 228-9749

FROM: \_\_\_\_\_

### PATIENT INFORMATION:

\_\_\_\_\_  
Address (including City, State, Zip Code)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

### RELEASE OF INFORMATION

I hereby give authorization to San Antonio Kidney Disease Center Physicians Group, P.L.L.C. to release information to all physicians involved in my care including such information as Hepatitis or AIDS/HIV test results as well as other physicians records and hospital records that are a part of my medical records.

Signature: \_\_\_\_\_  
Patient, Parent or Guardian

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

This form is valid in original and/or photocopied form as an original. This form is valid for the duration of treatment or otherwise revoked by the patient in writing.