

IMPACT Physicians of Texas
21 SPURS LANE
SAN ANTONIO, TEXAS 78240

Date: _____

1). I hereby authorize _____ to release the following information from the health record(s) of:

Patient Name

Address, City, State, Zip

Covering the period(s) of hospitalization from:

Date of Admission: _____

Date of Discharge: _____

Hospital No: _____

Date of Birth: _____

2). Information to be released:

- Copy of (complete) health record(s)
- History & Physical
- Operative Report
- Discharge Summary
- Pathology Reports
- Other _____

3). Information to be released to:

IMPACT Physicians of Texas
21 SPURS LANE Suite 230
SAN ANTONIO, TEXAS 78240
PHONE: (210) 690.0202
FAX: (210) 690.0206

4). Purpose of disclosure: _____

5). I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6). Specification of the date, event, or condition upon which this consent expires or in 90 days.

7). The facility, its employees, and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed: _____

Relationship to Patient: _____
(if applicable)

Date: _____