

CARITAS

FAMILY MEDICINE

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San Antonio, TX 78233
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REQUEST TO OBTAIN MEDICAL RECORDS

I hereby request that my medical records be released to the address above from:

Physician Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Records to include:

- All records
- Only the following:
- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Office notes | <input type="checkbox"/> Hospital notes | <input type="checkbox"/> EKG | <input type="checkbox"/> Xray reports |
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Lab reports | <input type="checkbox"/> General correspondence | |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Billing records | <input type="checkbox"/> Substance Abuse Record | |
| <input type="checkbox"/> Results of HIV testing | <input type="checkbox"/> Mental Health Treatment Records | | |
- Other: _____

PLEASE CHECK IF YOU DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:

- HIV/AIDS (including test results) Substance Abuse Record Mental Health Treatment Records

Reason for request:

- | | | |
|--|--|--|
| <input type="checkbox"/> Transfer to new physician | <input type="checkbox"/> Specialist Consultation | <input type="checkbox"/> Change of insurance |
| <input type="checkbox"/> Insurance company request | <input type="checkbox"/> Moving | <input type="checkbox"/> Attorney request |
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Other | |

Patient's Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

THIS AUTHORIZATION AUTOMATICALLY EXPIRES ONE YEAR FROM DATE OF SIGNATURE,
UNLESS OTHERWISE NOTED.