Juanita H. Sprute M.D.
Diplomate American Board of Family Medicine

GENESIS MD

Alaina D. Hallmark M.D.
Diplomate American Board of Family Medicine

I Authorize:

_____
Name of Person/Organization

_____
Street Address

_____
City State Zip

To Release to:

Genesis MD
9647 Huebner Rd.
San Antonio, TX 78240
210-759-1404 (FAX)
210-759-1420 (PHONE)

Information to be released: (check all applicable)

All Information All Progress Notes Electrocardiogram Allergy Records

Lab Reports X-ray Reports Immunization Records Other_____

SPECIAL AUTHORIZATION: By signing below, I am authorizing the office to also release any and all information regarding (circle):

Alcohol Mental Health

Drugs HIV/AIDS

Records requested for period_/_/____through_/____/

Purpose of Disclosure:

Continuity of Care Payment of lnsurance Claim Legal Personal

I understand that this authorization shall be for one year. I understand that I may revoke this consent at any time (in writing), except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

Patient Name (please print):_____

Patient's Signature: _____Date: _____

Date of Birth: _____ Phone:_____