

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



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
15303 Huebner Rd.
Bldg 7
San Antonio, TX 78248
P: 210-759-1420
F: 210-759-1404

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 Insurance 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: _____