

**REQUEST TO RELEASE MEDICAL RECORDS**

TO: \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient's authorization to release medical records and X-Rays:

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthday: (Month/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Representative      Date

**If signed by Authorized Representative:**

Relationship to Patient: \_\_\_\_\_ Age of Authorized Representative: \_\_\_\_\_

\_\_\_\_\_  
Witnessed by      Date

**Please release records to:**

**The Orthopaedic Specialists of South Texas**

Mark M. Casillas, M.D.  
Jeremy L. Dickerson, M.D.  
Stacé S. Rust, M.D.

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San Antonio, TX 78205**

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