The Orthopaedic Specialists of South Texas

INNOVATIVE. EXCELLENT. CARE.

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.

414 Navarro Street, Suite 1616
San Antonio, TX 78205

Phone: 210.224.2655
Fax: 866.644.0889