



## WOUND CARE and HYPERBARICS

### Medical Records Release Form

Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

#### INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical Consultation Report Emergency Room Record  
Operative Reports Discharge/Death Summary Face Sheet  
Lab/Path Reports X-Ray Reports/Images Other: \_\_\_\_\_

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

R3 Wound Care and Hyperbarics, 9150 Huebner Rd Ste 120, San Antonio, Tx, 78240.  
Phone Number 210-582-5304

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_