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Medical Records Release Form

I HEREBY REQUEST THAT ALL MY MEDICAL RECORDS BE RELEASED TO:

- DR. JUAN PABLO GOMEZ
- DR. RODRIGO LEMA
- DR. JUAN PABLO CALERO

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Date: _____

PATIENT SIGNATURE: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information. I understand that you will provide this information within 15 days from receipt of request according to rulings set forth by the Texas Medical Board.