



**Porter Medical Associates**  
**Authorization for release of information**

I \_\_\_\_\_, DOB \_\_\_\_\_, SS# \_\_\_\_\_  
(Patient Name)  
hereby authorize,

Dr. \_\_\_\_\_ located at:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

To release my confidential medical records to:

**Porter Medical Associates**  
**2829 Babcock Rd Suite 117 San Antonio, Texas 78229**  
**P: (210) 341-9614 F: (210) 340-5924**

I authorize the selected information to be sent: (Please check all that apply)

- \_\_\_\_\_ **All Below** (this will include all that was done in clinic)
- \_\_\_\_\_ Treatment and prognosis of any physical or mental condition
- \_\_\_\_\_ Psychiatric history or treatment
- \_\_\_\_\_ Drug or alcohol abuse history or treatment
- \_\_\_\_\_ Infectious or contagious disease information including HIV/AIDS
- \_\_\_\_\_ Living Will
- \_\_\_\_\_ Durable Power of Attorney of Healthcare
- \_\_\_\_\_ Immunization records
- \_\_\_\_\_ Billing Statements

Purpose of Records Release: \_\_\_\_\_

I agree that copies of this authorization may be used in place of the original. I also understand that this consent shall automatically expire ninety (90) days from the date set forth below

(Signature) \_\_\_\_\_ Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(Signature if Minor Patient) \_\_\_\_\_ Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

2829 Babcock Rd | Suite 117 | San Antonio, Texas | 78229 | Ph. 210-341-9614 | Fax. 210-340-5924  
2318 Pat Booker Rd | Universal City, Texas | 78148 | Ph. 210-341-9614 | Fax. 210-340-5924  
1200 Brooklyn Ave | Suite 220 | San Antonio, Texas | 78212 | Ph. 210-341-9614 | Fax. 210-340-5924  
10423 State Hwy 151 | Suite 101 | San Antonio, Texas | 78251 | Ph. 210-341-9614 | Fax. 210-340-5924  
2020 Sundance Pkwy | Suite A2 | New Braunfels, Texas | 78130 | Ph. 830-387-2110 | Fax. 830-609-9918