Porter Medical Associates

Release of Medical Information

I, _____, date of birth _____ hereby give permission to **Porter Medical Associates** to release any or all of my medical information, including AIDS/HIV, mental health, and alcohol/drug related issues.
to:

Name: Relationship:

1._____

2._____

3._____

4._____

□ Progress Notes as requested
□ Labs and X-rays
□ Correspondence
□ Personal Demographics
□ Diagnosis
□ Other Information_____

_____ _____
Patient/Guardian Signature Date

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. 210-226 | 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