Roland J Dominguez MD PA
2829 Babcock, Suite 407
San Antonio, TX 78229
Phone: (210) 614-5437 Fax: (210) 949-5051

Medical Records Release Form

(Please Circle Release or Request)

Patient Name: _____ Date of Birth: _____

By signing this form, I hereby authorize the release or request of medical records to the person(s) or entity above.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone:_____ Fax: _____

□ Complete Medical Chart
□ Sick / Well visit
□ Immunization Record
□ Lab or x-ray results
□ Hospital Results
□ Other

HIV/AIDS: I CONSENT TO THE RELEASE OF ANY POSITIVE OR NEGATIVE RESULT FOR HIV/AIDS WITH THE REST OF MY MEDICAL RECORDS

I, the undersigned, have read the above and authorized the Roland J Dominguez MD PA to disclose or request such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-discloser o this information to a party other than the designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and undersigned will hold the facility harmless, for complying wit this "Authorization for Release of Medical Information."

This authorization expires one year from the date signed below.

I understand that you will provide this information within 15 days from the receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.

_____

Parent/Guardian Signature (If over 18 years of age) Date