**Roland J Dominguez MD PA**

**2829 Babcock, Suite 407**

**San Antonio, TX 78229**

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**Medical Records Release Form**

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| (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 □ Lab or x-ray results  □ Sick / Well visit □ Hospital Results  □ Immunization Record □ 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 I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.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