Byron L. Limmer, M.D. and Rachel L. Limmer, M.D., P.A.
14615 San Pedro Avenue
Suite 210, One Medical Park
San Antonio, TX 78232
Phone: 210-496-9929 Fax: 210-496-6699

Medical Record Release Form

Patient Name: ____

Patient Date of Birth: ________________________

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

[ ] Complete records
[ ] Records of care from the following dates ___/___/_____ to ___/___/_____
[ ] Records concerning the following condition: _______________________
[ ] Most recent lab results
[ ] Other, please specify: ____
[ ] Confer/talk with person(s) listed below about my medical information:

____

The reason or purposes for this release of information are as follows:

____

____

HIV / AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any causative agent of AIDS with the rest of my medical records. Initial: _____________ Date: ____________

Release the above mentioned records to the following person(s)/entity:

Byron L. Limmer, M.D., and Rachel L. Limmer, M.D., P.A.
14615 San Pedro Ave, Suite 210
San Antonio, Texas 78232

Fax # 210-496-6699 Phone # 210-496-9929

Records Requested From:

Name: ____

Address: ____

City ____________________________State _________________ Zip ________________

Fax # _______________________________ Phone # ______________________________

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

____ _________________

Patient (or Legal Guardian) Signature Date

Approved 6/11/2014