

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:

Name: _____

Address: _____

City _____ State _____ Zip _____

Fax # _____ Phone # _____

Records Requested From:

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

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