MEDICAL RECORD RELEASE FORM

Date: ___________________

From: ___________________________________

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Date of Birth: _____________________
E-mail address: ____________________

To: **William Stavinoha, MD**
7311 Stonewall Hill,
San Antonio, TX 78256

This authorizes William Stavinoha, MD to release my entire MEDICAL RECORD to the following individual or recipient:

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The reason or purposes for this release are as follows:

- Continuation of medical care
- Other reason (optional) ____

I understand that upon receipt of my signed consent for release of medical record and **$25 check (made to William Stavinoha, MD)** for copy fee, my medical record will be sent within 15 business days.

I understand that my medical record includes record of office visits, telephone correspondence, reports of laboratory and radiological testing. Also included are all correspondence received from other healthcare providers, refill and referral records.

I understand that this record will be sent via the US Postal Service on computer disk.

Patient (guardian, if patient minor) ____

PLEASE PRINT, COMPLETE AND SEND WITH COPY FEE