Authorization to Release Records

Please note that this is to obtain records from a non-Pro-Care facility for continuity of care. Records are necessary to avoid duplicate treatments and tests, and to allow for the highest quality of care from our providers. You are not required to complete this form; however, it may result in delayed treatment due to repeating tests and exams.

Patient Name ____

Date of Birth _______/________/_________

Requesting Pro-Care Provider ______________________Office Contact______________________

I hereby authorize the following facility and/or provider (non-Pro-Care provider) ______________________
to release the records indicated below to Pro-Care Medical Center.

Please indicate the information to be released.
___ Doctor's notes

___ Imaging MRI CD

___ Imaging X-ray Report(s) ONLY

___ Lab Report(s)

___ Records obtained from other hospitals, physicians, or clinics

___ Billing record(s)

___ Other ____________________

Indicate treatment period below. If nothing indicated, please include all medical records.

From _____/_____/_____ To _____/_____/_____

Please send information to the following location:

_____ 1015 W 39 ½ St, Austin, TX 78756, Ph: (512) 371-7478, Fax: (512) 371-3861

_____ 701 E Whitestone Blvd, Ste 100, Cedar Park, TX 78613, Ph: (512) 371-7478, Fax: (512) 371-3861

_____ 9502 Huebner Rd, Ste 102, San Antonio, TX 78240, Ph: (210) 881-0630, Fax: (210) 641-1608

_____ 9727 Poteet Jourdanton Fwy, Ste 101, San Antonio, TX 78211, Ph: (210) 881-0630, Fax: (210) 641-1608

_____ 7403 W Loop 1604 N, Ste 103, San Antonio, TX 78254, Ph: (210) 881-0630, Fax: (210) 641-1608

Patient Signature Date