Healthcare
Medical Release Form

Jose E. San Martin, M.D.
OBSTETRICS / GYNECOLOGY
286 Ed English Dr Unit C Shenandoah Tx, 77385
P: 281-651-2090 F: 281-607-5700

Patient Information:

Last name	First name
Social Security - -	DOB
Address	City	State
Zip Code	Phone Numbe ( ) - -

Please check ONE of the following options:

☐ I wish to request my medical records from the doctor(s) listed below to be sent TO Dr. Jose San Martin OBGYN.

☐ I wish to request my medical records to be sent FROM Dr. Jose San Martin OBGYN to the doctor(s) below

PLEASE COMPLETE IN FULL OR RECORDS MAY NOT BE ABLE TO BE SENT OR RECEIVED

Dr.	Address	
City	State	Zip
Phone	Fax	
Authorization covers care given during the following dates:	From:	To:
Dr.	Address	
City	State	Zip
Phone	Fax	
Authorization covers care given during the following dates:	From:	To:
Dr.	Address	
City	State	Zip
Phone	Fax	
Authorization covers care given during the following dates:	From:	To:
Dr.	Address	
City	State	Zip
Phone	Fax	
Authorization covers care given during the following dates:	From:	To:

The records I wish to be sent or received are: (check all that apply)

☐ History
☐ Operative Report
☐ Lab report
☐ Care plan
☐ Physical
☐ Progress notes
☐ X-ray or Mammo
☐ Therapy Report
☐ EKG Report
☐ Psychological Report
☐ ALL RECORDS
☐ Other ___________________________

The reason I want these records or information transferred is:

☐ For Medical Care.	☐ For my attorney	☐ For my insurance Company

• The patient agrees that a copy of this authorization may be considered valid	☐ Yes	☐ No
• Are you pregnant at this time?	☐ Yes	☐ No
• Are you transferring care to another physician?	☐ Yes	☐ No
• If so, please explain why:		

Patient Signature Authorizing Request/Release: Signature:	Date:
Physician's Signature Authorizing Request/Release: Signature:	Date: