



PRO·CARE

MEDICAL CENTERS

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

_____ 4544 S Lamar Blvd, Ste 700, Austin, TX 78745, 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

_____ 11900 Crownpoint Dr, Ste 112, San Antonio, TX 78233, Ph: (210) 881-0630, Fax: (210) 641-1608

Patient Signature

Date