ONCOLOGY
SAN ANTONIO
CANCER CARE NETWORK

Medical Records Release Authorization

Patient name: _____ Date of Birth: ____ / ____ / _____

Address: _____

Phone Number: (_____) _____-_____ Treatment dates from: ____ / ____ / _____ to ____ / ____ / _____

I authorize: (enter your current provider's information)

Provider name: _____

Address: _____

Phone Number: (_____) _____-_____

Fax Number: (_____) _____-_____

To release copies of my medical records to: (select provider)

ONCOLOGY SAN ANTONIO

Jayasree Rao, MD
215 East Quincy Street, Suite 100B
San Antonio, TX 78215
O: 210-490-2707 F: 210-224-2701

For the purpose: _____

I understand that this information shall be in effect for one year following the date of signature. However, I understand that this authorization may be revoked at any time by giving oral or written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the released copies.

I hereby release *Oncology San Antonio* from any and all liability which may arise as a result of my authorized release of records. Should my case require review by a governing agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Signature of Patient or Guardian: **Date:**

_____ ____ / ____ / _____