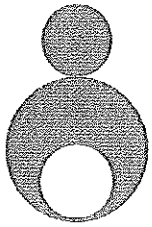

PERINATAL ASSOCIATES
OF SAN ANTONIO

502 Madison Oak Ste. 210, San Antonio, TX 78258 ● 210-481-3000 Fax: 210-496-0042

AUTHORIZATION FOR PFSSA TO RELEASE MEDICAL INFORMATION

Patient Name_____

Address_____

Date of Birth_____ Social_____

I authorize Perinatal Associate of San Antonio, P.A to release of the following specific medical information: _____

_____

_____

I authorize Perinatal Associate of San Antonio, P.A. to release of the following specific medical information to:

Name: _____ Organization _____

Address_____

_____

Phone_____ Fax_____

This information is to be released specifically for the purpose of:

_____

_____

(disability insurance, life insurance, work release, care coordination, etc.)

_____ _____

Patient's signature Date

_____ _____

Patient's printed name Phone Number

This authorization expires two weeks from the above date. I have the right to revoke this authorization at any time prior to the date, by providing my intent to revoke in written form. I understand that there is a $25 fee for copying the request information. I have been notified of this policy and agree to pay accordingly.