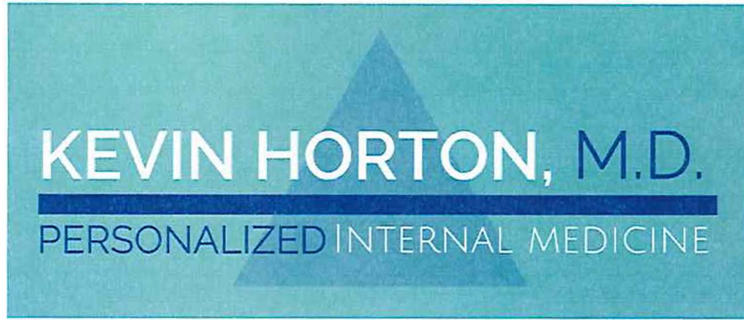

KEVIN B. HORTON, MD, PA
AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT NAME:______________________________ **DATE OF BIRTH:**______________

ADDRESS:____

PHONE: (____) ___________ **MOBILE: (____) ___________** **WORK: (____) ___________**

I hereby authorize:

Physician/Facility:____________________ **Address:**________________________________

Phone: (____) ___________ **Fax: (____) ___________**

to release my protected health information to:

Kevin B. Horton, MD, PA
1202 E. Sonterra, Ste. 401
San Antonio, TX 78258
phone: 210.469.3790
fax: 210.281.8957

Information to be released:

__ Complete Medical Record __ Labs __ Radiology Reports __ Procedure Report __ Progress Notes

Comments:____

The disclosure is being made for the following purposes:

- **I understand and acknowledge that this authorization extends to all or part of the records designated above, which may include treatment for physical and mental illness and/or alcohol/drug abuse.**
- **I consent to the release of information as designated above**
- **This consent may be revoked by me in writing to Kevin B. Horton, MD before release of the above-designated information.**

____
Patient or Legally Authorized Representative Signature

____
Date