KEVIN HORTON, M.D.
PERSONALIZED INTERNAL MEDICINE

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