GIL R VILLANUEVA, MD PA
1162 E SONTERRA SUITE 110
SAN ANTONIO, TEXAS 78258

Date: _____

1). I hereby authorize _____to release the following information from the health record(s) of :

_____
Patient Name

_____
Address, City, State, Zip

2). Information to be released:

⊗ Copy of (complete) health record(s)

3). Information to be released to:

GIL R VILLANUEVA, M.D., P.A.
1162 E SONTERRA SUITE 110
SAN ANTONIO, TEXAS 78258
PHONE: (210) 494-8100
FAX: (210) 494-8106

4). Purpose of disclosure: _____CONTINUED MEDICAL CARE_____

5). I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6). The facility, its employees, and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed: _____ Date: _____