

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

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Date: \_\_\_\_\_

1). I hereby authorize Northeast Ob/Gyn Assoc. 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: \_\_\_\_\_

**PLEASE FAX THIS FORM TO:**  
**NORTHEAST OB/GYN ASSOC.**  
**VILLAGE DR. OFFICE**  
**FAX: (210)653-8137**