



"Our mission is to provide exceptional health care services with compassion and promptness."

Medical Release Authorization

I hereby authorize the following people to receive any and all test results, general medical condition and your diagnosis (including treatments and billing). I also understand that information relevant to HIV testing and/or AIDS related diagnosis may be contained in this information. This list also includes people who can be reached in an emergency situation.

Print Name	Relation	Phone Number	Email
Print Name	Relation	Phone Number	Email
Print Name	Relation	Phone Number	Email

Please print an address of where you would like your billing statements and/or correspondence from our office to be sent **if different than address already provided to us.**

Address	Apt#/PO BOX	City	State
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Please indicate if you want all correspondence from our office sent in a sealed envelope.

Yes No

Please indicate if a confidential message can be left on your telephone/cell phone answering machine or voicemail.

Yes No

(Please check one box below)

I DO authorize anyone listed above to receive any test results or medical history.

I DO NOT authorize anyone to receive any test results or medical history.

Patient Print	Name Signature	Date
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I will not hold South Alamo Medical Group Physicians or Staff responsible for release of information related to the above without my signature.

Under no Circumstances can any changes be made verbally.

All mail must be sent to South Alamo Medical Group, PO Box 240490, San Antonio, TX 78224

Centralized Office Phone # 210-222-0333

Centralized Fax # 210-928-4837

Downtown

740 South Alamo
210-222-0333
Fax 210-928-4837

Pediatrics

7355 Barlite, Ste 201
210-222-0333
Fax 210-928-4837

Southside

7355 Barlite, Ste 301
210-222-0333
Fax 210-928-4837

Southeast

4203 E. Southcross
210-222-0333
Fax 210-928-4837

Northwest *NEW

9215 Westover Hills Blvd
210-222-0333
Fax 210-928-4837