



RHEUMATOLOGY ASSOCIATES of SOUTH TEXAS

Kevin J. Kempf, M.D. Everett H. Allen, M.D. Thomas A. Rennie, M.D.

Gautam Moorjani, M.D. Emily T. Marx, M.D.

19272 Stone Oak Parkway Suite 101 San Antonio, TX 78258 (210) 265-8851 Fax: (210) 265-8855

3903 Wiseman, Ste 221, San Antonio, TX 78251 (210) 448-4344 Fax: (210) 448-4347

Medical Record Request Form

Requesting information on the following patient:

Patient Name: _____

DOB: _____

Patient/Sponsor's SSN (Military Release only): _____

REQUESTING PHYSICIAN:

____ Dr. Kevin Kempf ____ Dr. Everett Allen ____ Dr. Thomas Rennie
 ____ Dr. Gautam Moorjani ____ Dr. Emily T. Marx

AUTHORIZING RECORDS TO BE RELEASED TO and/or FROM:

Physician First & Last Name: _____

Phone Number: _____ Fax: _____

I hereby authorize the release of all medical records in your possession regarding my illness/treatment as indicated to the requesting physician. I understand that the disclosed information may be subject to re-disclosure by the recipient. Please forward all records to:

Rheumatology Associates of South Texas

____ Stone Oak Location/ Main Office

19272 Stone Oak Parkway Ste. 101

San Antonio, TX 78258

FAX NUMBER: 210-265-8854

Phone Number: 210-265-8851

____ Wiseman/Westover Hills Location

3903 Wiseman, Ste 221

San Antonio, TX 78251

FAX NUMBER: 210-448-4347

Phone Number: 210-448-4344

RECORDS REQUESTED: *Please send only the most recent unless otherwise specified.*

____ Progress Notes

____ Labs

____ MRI

____ DEXA

____ X-Rays

____ Other _____

Patient Signature: _____ Date: _____

(This authorization is valid for 180 days from signed date and may be revoked in writing at any time.)