PRO·CARE
MEDICAL CENTERS

Authorization to Release Records

Patient Legal Name	DOB	Last 4 of SSN

Select One of the Following:

☐ **I am requesting my records to be sent to Pro-Care.** *This is to obtain records from a non-Pro-Care facility for continuity of care. Records are necessary to avoid duplicate treatments and tests, and to allow for the highest quality of care from our providers. Without records, it may result in delayed treatment due to repeating tests and exams.*

☐ **I am requesting my Pro-Care records to be sent to another facility, clinic, doctor, or person.**

I authorize the following facility and/or provider to release the records indicated below to Pro-Care Medical Center.

Please list the Dr/Facility to release records to Pro-Care:

Dr/Facility Fax Number:

I authorize Pro-Care Medical Center to release the records indicated below to the facility or doctor listed below.

Please list the Dr/Facility who will receive Pro-Care records:

Dr/Facility Fax Number:

Please indicate the Pro-Care location where records should be sent (fax preferred when applicable).

Austin Area Fax: (512) 371-3861 / Ph: (512) 371-7478
San Antonio Fax: (210) 641-1608 / Ph: (210) 881-0630

- ☐ 1015 W 39th ½ St, Austin, TX 78756
- ☐ 4454 S Lamar Blvd, Ste 700, Austin, TX 78745
- ☐ 894 Summit St, Ste 108, Round Rock, TX 78664
- ☐ 9502 Huebner Rd, Ste 102, San Antonio, TX 78240
- ☐ 9727 Poteet Jourdanton Fwy, Ste 101, San Antonio, TX 78211
- ☐ 11900 Crownpoint Dr, Ste 112, San Antonio, TX 78233

Please indicate the reason for sending records.

- ☐ Continuing care with a different specialty
- ☐ Switching providers
- ☐ Moving out of the area
- ☐ Billing or payment purposes
- ☐ Other:

Please indicate the records and information to be released.

☐ Doctor's Notes	☐ Lab Reports	☐ Records From Other Hospitals, Doctors, or Clinics
☐ Imaging Reports	☐ Other:	

Please indicate the dates to be released.

☐ All Dates	☐ From _____/_____/_____ To _____/_____/_____

Patient Signature **Today's Date**

Completed form with a signature can be faxed, dropped off, mailed to any location, or emailed to records@procaremedcenter.com.