

Request for Medical Information

Date:

Patient's Name:

Date of Birth:

I hereby authorize and request Carlos E. Diaz, M.D. to release the complete history and records in possession concerning my illness or treatment; in furtherance of this authorization, I hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Please mail to:

Carlos E. Diaz, M.D.
1015 N Texas Blvd, Suite 20B Box 186
Weslaco, TX 78596

Fees:

Please include a check (made out to Carlos Diaz, M.D.), money order or cash for \$25.00 to cover the first 20 pages. Additional pages will be billed at \$0.50 each. This is to cover copying (labor and supplies) and postage fee. This is in compliance with Texas Medical Board Rule Chapter 165 (165.2.e).