Noe R. Olvera, M.D., P.A.
2705 Hospital Dr. Suite 210
Victoria, Texas 77901
(361) 574-1893
Fax (361) 574-1894

REQUEST FOR RECORDS RELEASE

Physician's Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Dear Doctor: _____:

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name: _____

Birthdate: _____ Social Security Number: _____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of the following:

____ H & P	____ X-ray Reports	____ Consult Notes
____ Progress Notes	____ Pathology Reports	____ MRI Reports
____ Laboratory Studies	____ Infusion Records	

Thank you for expediting this request. Please send these records to our office address shown above or fax to **(361) 574-1894**.

I hereby authorize the release of all necessary medical records to Dr. Noe R. Olvera. I wish for them to be forwarded as soon as possible.

Patient's Signature: _____ Date: _____

Patient's Address: _____

City: _____ State: _____ ZIP Code: _____