South Texas Women's Health Center, PA
Juan Carlos Rivera MD
Obstetrics • Gynecology • Infertility

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security#: _____

I request and authorize _____ to release health care information of the patient named above to Dr. Juan Carlos Rivera at ***South Texas Women's Health Center, PA*** at 320 Lindberg, McAllen, Texas 78501.

This request and authorization applies to:

- ☐ Health care information to the following treatment, condition or dates: _____
- ☐ All health care information
- ☐ Labs
- ☐ Other

Patient Signature _____ Date signed _____

320 Lindberg, McAllen, Texas 78501
956-630-0090 | fax 956-630-0099