Mark
Thornton, M.D.
Personal Physician

7720 Jones Maltsberger | Suite 110
San Antonio, TX 78216 | Ph. 210.822.2004
Fax: 210.822.2215

MARK L. THORNTON, MD, FACP / EXECUDOC, INC.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name: Last, First	Date of Birth
SocialSecurity Number	Telephone Home: ( ) Work: ( )

I Hereby Authorize:

Facility or Doctor ______________________________

Address ______________________________

Phone and Fax ______________________________

To Release to the Following Person:

MARK L. THORNTON, MD, FACP/EXECUDOC, INC.
7720 Jones Maltsberger, Suite 110
San Antonio, Texas 78216
Telephone (210) 822-2004 • Fax (210) 822-2215

Reports to be released (please indicate)

- ❑ Complete Medical Record
- ❑ Lab Results
- ❑ Conversations by Telephone
- ❑ History and Physical
- ❑ Referral Letters
- ❑ HIV Test Results
- ❑ Test Results
- ❑ Progress Notes
- ❑ Other: ______________

This disclosure is being made for the following purpose(s):

- ❑ Continuing Care/Referral
- ❑ Transfer of Care
- ❑ Insurance
- ❑ Attorney/Court Case
- ❑ Workers Compensation
- ❑ Personal Reasons
- ❑ Other: ______________________________

I understand and acknowledge that this authorization extends to all or part of the records designated above, which may include treatment for physical and mental illness, and/or alcohol/drug abuse. I expressly consent to the release of information as designated above. This consent is valid for 180 days, unless revoked by me in writing before release of the above-designated information.

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Patient Signature and Date