Mark Thornton, M.D.
Personal Physician

Mark L. Thornton, MD, FACP / Execudoc, Inc.

Authorization for the Release of Medical Records

Patient Name (*Last, First*): | Date of Birth:

Social Security Number: | Telephone:

Home: ( ) Work: ( )

I Hereby Authorize:

Facility or Doctor:

Address:

Phone and Fax:

To Release to the Following Person:

Mark L. Thornton, MD, FCAP / Execudoc, Inc. | 7720 Jones Maltsberger | Suite 110

San Antonio, TX 78216 | Ph: 210 822.2004 | Fax: 210 822.2215

Reports to be Released *(please indicate)*

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

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

- ☐ Continuing Car/Referral
- ☐ Attorney/Court Case
- ☐ Other
- ☐ Transfer of Care
- ☐ Worker's Compensation
- ☐ Insurance
- ☐ Personal Reasons

I understand and acknowledge 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 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.

Patient Signature and Date