Olga L. Gomez M.D., P.A.
Children's Clinic

Medical Release Form

Dear Dr. / Clinic _____ Phone: _____

Address _____

I hereby request that my medical records be released to Dr. Olga L Gomez M. D.

_____ Complete medical record & vaccines

_____ Records of care from _____ to _____ only.

_____ other, specify
_____

For the following patient

Name _____

D.O.B _____

The reason or the purpose of this release is

_____

_____

Signature _____ Date _____
(Patient or person legally authorized to consent on patient's behalf)

Dr. Olga Gomez Children's Clinic
Phone: (956)969-1313 Fax: (956)969-1322
910 E 8th Street suite 3 Weslaco,Tx 78596