

THOMAS H. RAETZSCH, M.D.
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**MEDICAL REQUEST RELEASE REQUEST
PATIENT INFORMATION**

Patient's Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

I hereby authorize the release of my medical records

FROM the following physician or facility:

Name of Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax _____

TO the following physician or facility:

Thomas H. Raetzsch, MD
1025 N. Austin St.
Seguin, TX 78155
Ph: (830) 379-1184
Fax: (830) 303-2314

Patient Signature

Date