JJ Saenz, M.D.,P.A.● Daniella Rodriguez-Rico, M.D. ●Jennifer Saenz-Siedow, M.D.
Melissa Ledesma, PA-C● Marla Garza, PA-C ●Erica Tijerina, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records from: _____

_____

_____

Phone#: _____ Fax#: _____

Patient's Name:_____ D.O.B_____
(Nombre de Paciente) **(Fecha de Nacimiento)**

Patient's Name:_____ D.O.B_____
(Nombre de Paciente) **(Fecha de Nacimiento)**

Please send:
☐Entire Record
☐Mental Health Record
☐Labs/X-Rays
☐Medication Hx
☐Immunizations

Reason for Request:
☐Moving
☐Social Service/Disability
☐Attorney/Legal
☐Insurance
☐Personal/Other_____

To: Pediatric Center at Renaissance
2821 Michael Angelo Drive Suite#102
Edinburg, Texas 78539
Office#:956-686-6100 Fax#:956-686-6115

Email completed form to:
medrecs@saenz.pcc.com

Signature of Parent or Guardian:_____
(Firma de Papas o Tutor)

Date: _____ Relationship to Patient:_____
(Fecha de Hoy) (Relacion al Paciente)

For Office Use Only Requested By: _____