JJ Saenz, MD ● Jennifer E. Saenz, MD
Joaquin Garza PA-C ● Melissa Ledesma PA-C ●Erica Tijerina, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records from: ____

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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
5300 North G Street, Suite 140
McAllen, Texas 78504
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: ___________________________________