



EMERGENCY ROOM - HOSPITAL NOTIFICATION

DATE _____

EMPLOYER: _____

EMPLOYEE: _____

DATE OF INJURY: _____

OUR PHYSICIAN IS: **TEXAS MEDCLINIC**

Blanco/Parliment
11811 Blanco Road
San Antonio, Texas 78216
341-5588
FAX: 341-7513

IH 10/Wurzbach
9895 IH-10 West
San Antonio, Texas 78230
696-5599
FAX: 699-8152

Loop 410/Broadway
1007 N.E. Loop 410
San Antonio, Texas 78209
821-5598
FAX: 829-0125

IH 35 N/Eisenhauer
7460 IH 35 North
San Antonio, Texas 78218
655-5529
FAX: 655-5504

SE Military/Roosevelt
1111 SE Military Drive
San Antonio, Texas 78214
927-5580
FAX: 927-2700

Bandera/West1604
9207 N Loop 1604 West
San Antonio, Texas 78249
695-4884
FAX: 695-4949

IH 35 N/Hwy 46
958 IH 35 North
New Braunfels, Texas 78130
830-606-5533
FAX: 830-606-5535

Loop 410/Ingram
6570 Ingram Road
San Antonio, Texas 78238
520-5588
FAX: 522-1125

I-35/Loop 1604
8341 Agora Pkwy
Selma, Texas 78154
659-5533
FAX: 659-7755

IH 10/Leon Springs
23611 IH 10 West
San Antonio, Texas 78257
698-6617
FAX: 698-6627

Please have the patient sign the release form below, check the appropriate box above, and fax the medical records to the correct Texas MedClinic. By previous arrangement, Texas MedClinic has been instructed to follow-up on each injury and report back to our company. We ask you to provide urgent/emergent care only. We appreciate your cooperation and attention to our patients.

I, (patient) _____, authorize (hosp.) _____,
to release my medical records, together with the results of all X-Rays and lab tests to the Texas MedClinic location annotated above. I agree not to hold the hospital, physicians, or its representatives responsible for any action that may be taken as a result of the release of this information.

Signed: _____ Date: _____