Request for Medical Records to be Released from
Pediatric Associates of Austin, P.A.

Office: (512) 458-5323 Fax: (512) 458-2030

I hereby request Pediatric Associates of Austin to release medical records for:

Patient Name:_____ DOB: _____

Address: _____ City/State:_____ Zip:_____

Home Phone: _____ Alternate Phone: _____

Released to:

Parent's Name:_____
Email Address:_____

All medical records will be sent to a PARENT ONLY, via a secure email.

The purpose of this request:

- ❑ Moving out of town
- ❑ Insurance Change
- ❑ Transferring to: _____
  (PRACTICE AND/OR PHYSICIANS NAME)
- ❑ Other – specify _____

Please specify what records are being requested:

- ❑ All records
- ❑ X-Rays
- ❑ Lab Results
- ❑ Specified Dates: _____
- ❑ Other: _____

Patient/Guardian Signature:_____ Date: _____

Relationship to Patient:_____

PLEASE ALLOW 15 BUSINESS DAYS FOR MEDICAL RECORDS TO BE PROCESSED