Austin Medical Group
Better Care Better Health

Authorization for Release of Medical Information

Patient full name: _____ Date of Birth ____/____/____

Previous/ Other Name if different than above: _____

I Authorize: My previous Physician and/or Hospital to release my Medical Records:

Name of Physician and/or Hospital: _____

Address: _____

City, State, Zipcode: _____

Phone: _____ Fax: _____

To release my records to:

Austin Medical Group, PLLC
12201 Renfert Way, Suite 315
Austin, Texas 78758
Phone: (512) 837-6000 Fax: (512) 837-6001

Medical Information Requested:

- ○ Lab Reports
- ○ Progress Notes, including Medication List
- ○ Immunization Records
- ○ RECORDS LAST YEAR
- ○ Other:_____

Reason for Release:

- ○ To update my regular doctor (Provider)
- ○ I have been referred to another doctor
- ○ Dissatisfaction with care
- ○ I am moving (New Address)
- ○ Other: _____

Specific Authorization for Release of information Protected by State and or Federal Law

○ Yes	○ No	Substance Abuse (Alcohol/Drug use)
○ Yes	○ No	Mental Health/Depression (includes Psychological testing)
○ Yes	○ No	HIV-related information (AIDS related testing)

This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

_____ _____
Signature of Patient or Authorized representative Witness

_____ _____
Date Date