Date received __________

Medical Records Release Authorization

(To have another physician send records to P.A.)

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

PLEASE ALLOW 15 DAYS FOR MEDICAL RECORDS

TO: ______________________________
(PHYSICIAN'S NAME)

____
(STREET ADDRESS)

____
(CITY, STATE, ZIP CODE)

I hereby request the medical records on

______________________________ ______________
(PATIENT'S NAME) (PATIENT'S DATE OF BIRTH)

for ______________________________
(DATES, ILLNESS, ALL RECORDS, ETC.)

be released to: ______________________________
(PHYSICIAN'S NAME)

Pediatric Associates of Austin, P.A.
1500 W. 38th St., Suite 20
Austin, TX 78731

The purpose of this request:

- ☐ Moving
- ☐ Insurance Change
- ☐ Other – specify ______________________________

I understand that I may revoke this authorization at any time. My revocation must be in writing and provided to Pediatric Associates of Austin, P.A., but if I do, it will not have any effect on any actions the releasing took before they received the revocation.

______________________________ ______________
(PATIENT'S OR AUTHORIZED SIGNATURE) (DATE)

____
(RELATIONSHIP TO PATIENT)