

Date received _____

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

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

TO: _____
(PHYSICIAN'S NAME)

(STREET ADDRESS)

(CITY, STATE, ZIP CODE)

(EMAIL ADDRESS, FAX NUMBER)

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)

Return to: Pediatric Associates of Austin, P.A.

1500 W. 38th St., Suite 20

Austin, TX 78731

Email: patientcare@pediatricassociates.net

Fax: 512-458-2030

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)