

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 _____

(PATIENT'S OR AUTHORIZED SIGNATURE)

(DATE)

(RELATIONSHIP TO PATIENT)