

Pediatric Associates of Austin, P.A.
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Office # (512) 458-5323 Fax # (512) 458-2030

Medical Records Release Authorization
(For PAA to send to another physician)

I hereby request medical records for:

Patient's Name: _____ DOB: _____

Address: _____ City/State: _____ Zip: _____

Home #: _____ Alternate #: _____

Released To:

Physician's Name: _____

Address: _____ City/State: _____ Zip: _____

The purpose of this request:

- Moving
- Insurance Change
- Other _____

Please specify what records are being requested:

- All Records
- X-Rays
- Lab Results
- Specified Dates _____
- Other _____

Signature: _____

Date: _____

Relationship to Patient: _____

PLEASE ALLOW 15 DAYS FOR MEDICAL RECORDS TO BE PROCESSED