Authorization for Release of Medical Information

Date: _____

I hereby authorize: _____

_____

_____

To release information from the medical records of:

_____	_____	_____
Patient Name	**Date of Birth**	**Social Security No.**

To be released to: **Central Family Practice**
801 W. 34th Street, Suite 102
Austin, TX 78705
512-371-9260
Fax: 371-9550 (if less than 15 pages)

◆ ***PLEASE MAIL RECORDS IF OVER 15 PAGES*** ◆

Information to be released: ***(reports may include information on drugs/alcohol/psychological/ communicable disease treatment)***

- ☐ **History & Physical**
- ☐ **Laboratory**
- ☐ **X-Rays**
- ☐ **HIV/AIDS**
- ☐ **Other:** _____
- ☐ **Consultation**
- ☐ **EKG**
- ☐ **Progress Notes**
- ☐ **All Medical Records**

Date of treatment to be released: _____

Purpose of release of information:
- ☐ **Change of physician**
- ☐ **Application for insurance coverage**
- ☐ **Other:** _____

A "reason or purpose of release" is required by Texas law.

I understand that I may revoke this consent at any time except to the extent that actions have already been taken in reliance to it and that, in any event, this authorization expires automatically ninety (90) days from the date of signature.

_____

Patient or Legal Guardian Signature **Date**