

# Authorization for Release of Medical Information

Date: \_\_\_\_\_

I hereby authorize:

**Central Family Practice  
801 W. 34<sup>th</sup> Street, Suite 102  
Austin, TX 78705  
512-371-9260  
Fax: 371-9550**

To release information from the medical records of:

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security No.

to be released to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- |   |  |
|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation        |
| <input type="checkbox"/> Laboratory         | <input type="checkbox"/> EKG                 |
| <input type="checkbox"/> X-Rays             | <input type="checkbox"/> Progress Notes      |
| <input type="checkbox"/> HIV/AIDS           | <input type="checkbox"/> All Medical Records |
| <input type="checkbox"/> Other: _____       |  |

Date of treatment to be released: \_\_\_\_\_

Purpose of release of information:  Change of physician

Application for insurance coverage

Others: \_\_\_\_\_

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

\_\_\_\_\_  
INITIAL      Starting August 1st, 2009, there may be a charge of \$15.00 for copying  
                  medical records requested by patients.

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 day of signature.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date