



*Central Family
Practice*

801 W. 34th St., Ste. 102, Austin, TX 78705
Phone: 512.371.9260 Fax: 512.371.9550
www.centrafamily.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

In the event that my ultrasound examination lead to further diagnostic testing, I request and authorize my midwife or referring healthcare provider to release the results of such tests to:

Name: Central Family Practice

Address: 801 W. 34th Street, Ste. 102

City: Austin State: TX Zip Code: 78705

Patient Signature: _____ Date Signed: _____

THE FOLLOWING SECTION IS FOR OFFICE USE ONLY:

This request and authorization applies to Healthcare information relating to the following treatment, condition, or dates:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.