Date received _____

Request for Medical Records to be Released to
Pediatric Associates of Austin, P.A.

Office: 512-458-5323 Fax: 512-458-2030

TO: _____
(PHYSICIAN'S NAME)

_____
(STREET ADDRESS)

_____
(CITY, STATE, ZIP CODE)

_____
(EMAIL ADDRESS, FAX NUMBER)

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)

Return to: Pediatric Associates of Austin, P.A.
1600 W. 38th St., Suite 100
Austin, TX 78731
Email: patientcare@pediatricassociates.net
Fax: 512-458-2030

The purpose of this request:
- ☐ Moving
- ☐ Insurance Change
- ☐ Other – specify _____

I understand that I may revoke this authorization at any time. My revocation must be in writing and provided to Pediatric Associates of Austin, P.A., but if I do, it will not have any effect on any actions the releasing took before they received the revocation.

_____ _____
(PATIENT'S OR AUTHORIZED SIGNATURE) (DATE)

_____
(RELATIONSHIP TO PATIENT)