5100 W Hwy 290, Bldg 2, Ste 110
Austin, TX 78735
512-454-0406
512-4544380

THE Records Release Outgoing

MEDICAL RELEASE FORM (OUTGOING)

I authorize Austex Pediatrics to release medical records for the patient(s) listed below:

FIRST NAME	LAST NAME	DATE OF BIRTH

To:

NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

The purpose of this request: _____

I understand that the information in this health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information. I understand this information will be provided within 15 business days from receipt of request and that a fee for preparing and furnishing this information may be charged.

GUARANTOR ADDRESS: _____ STATE: _____ CITY: _____ ZIP: _____

Name: _____ Relationship: _____

_____ _____

Client Signature Date