AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____Date of Birth:_____

Address:_____

Phone:_____ ☐ Cell ☐ Home ☐ Work

I,_____, hereby authorize the release of medical information

☐ TO:
Caritas Pediatrics and Wellness
300 Beardsley Lane, Bldg E, Suite 101
Austin, TX 78746
Phone: 512-737-8780
Fax: 512-737-9640

☐ FROM:
Caritas Pediatrics and Wellness
300 Beardsley Lane, Bldg E, Suite 101
Austin, TX 78746
Phone: 512-737-8780
Fax: 512-737-9640

FROM:
Practice/Physician:_____

Address:_____

Phone:_____

Fax:_____

TO:
Practice/Physician:_____

Address:_____

Phone:_____

Fax:_____

Please release the following:

☐ All health information (incl growth charts and vaccine record)	☐ Consultation Reports ☐ Lab and Pathology Reports ☐ Radiology and Diagnostic Test Reports
☐ Clinical Notes (incl History/Physical Exam, Progress Notes, Discharge Summary)	☐ Other (please specify):

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases, and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records.

☐ Yes, I consent to the release of this information
☐ No, I do NOT consent to the release of this information

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature:_____ Date:_____

Printed Name:_____ Relationship to Patient:_____