FAMILY MEDICINE AUSTIN
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____SSN: _____

Address: _____ City, State, Zip: _____

I authorize the release of medical records from:

Clinic/ Doctor: _____

Address: _____

City, State, Zip: _____

Phone/Fax: _____

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

- ◯ History & Physical Exams for last ____ years
- ◯ Office Visits for last ____ years
- ◯ Medication/ Problem List
- ◯ Radiology for last ____ years
- ◯ Labs for last ____ years
- ◯ All Consultations
- ◯ Other _____

The Purpose for release is: Continuing Medical Care

◯ Yes ◯ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above. I understand that the person(s) above listed will be notified that I must give specific written permission before disclosure of these test results to anyone.

I understand that the information release is for the specific purpose stated above. Any other use of this information without patient's consent is prohibited. I understand that I have the right to revoke this authorization in written at any time. I understand there may be a charge for copies of my medical records.

Signature of Patient Date: