NORTH AUSTIN PEDIATRICS, P.A.

Leighton E. Ellis, M.D. **Erica C. Sharp, M.D.**
Christine Lam, D.O. **Rebekah Sperling, M.D.**
Kristen Pickering, M.D. **Laura Chesley, M.D.**
Chelsea Johnson, M.D. **Alyse Paull, FNP**

☐ 12201 Renfert Way, Ste. 110
Austin, TX 78758
Phone: (512) 491-5125
Fax: 888-833-7248
After Hours: (512) 660-5396

☐ 1401-B Medical Parkway, Ste. 100
Cedar Park, TX 78613
Phone: (512) 259-0900
Fax: 855-727-1552
After Hours: (512) 660-5396

☐ 709 South Bagdad Road
Leander, TX 78641
Phone: (512) 260-0101
Fax: 855-862-9297
After Hours: (512) 660-5396

Medical Release of Information Form

By signing this form, I authorize **North Austin Pediatrics, P.A.** to obtain a copy of the specific health information described:

□ immunization records □ growth chart □ problem list □ lab results
□ x-ray reports □ consults ____
□ entire chart □ other: ____

Name of Patient: ______________________________ Date of Birth: _______________

Name of Patient: ______________________________ Date of Birth: _______________

Name of Patient: ______________________________ Date of Birth: _______________

Obtain records from: ____

Address: ____

Phone: _____________________ Fax: ______________________

Please send records to: **Attention: Leander Office**
North Austin Pediatrics
709 South Bagdad Road
Leander, TX 78641
Fax 855-862-9297

Unless otherwise revoked, this authorization will expire six months from the date signed.
I understand that authorizing the disclosure of this health information is voluntary.

Signed By: ___________________________________ Date: __________________

Relationship to Patient: _________________________