NORTH AUSTIN PEDIATRICS, P.A.

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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: __________________