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: Austin Office**
12201 Renfert Way, Suite 110
Austin, TX 78758
Email: nappa@naustinpeds.com
Fax 855-727-1552

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: _____