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: **Email:** nappa@naustinpeds.com

□ 12201 Renfert Way, Ste. 11
Austin, TX 78758
Phone: (512) 491-5125
Fax: 888-833-7248

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

□ 709 South Bagdad Road
Leander, TX 78641
Phone: (512) 260-0101
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: _____