

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I hereby authorize: _____
Physician, Facility or Person

Mailing Address

City, State, Zip Code

Phone Number/Fax Number

To release copies of the medical records listed below to:

Mary C. Petropoulos, MD
11673 Jollyville Road, Suite 104
Austin, TX. 78759
(512) 338-5130 (512) 338-5112 Fax

This release pertains to:

Patient Name

DOB

Patient Name

DOB

Current Address

Current Phone Number

This authorization applies to:

_____ All Records
_____ Immunizations Only
_____ X-Ray and Lab Only

For the Purpose of:

_____ Medical Care
_____ Change of Physician due to insurance change
_____ Other (state below)

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial** _____
Date _____

This authorization is valid for 90 days from the date of signature by the participant.

Prohibition of Redislosure: Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

Signature of Parent or Legal Guardian

Date

The Parent or Guardian may revoke this authorization in writing at any time.

Relationship to Patient

THERE IS A \$15.00 CHARGE FOR RELEASE OF ANY MEDICAL RECORDS.