Cedar Park Pediatric & Family Medicine

Complete Medical Care for your Family

345 Cypress Creek Road # 104
920 N. Vista Ridge Blvd. #500
Cedar Park, TX 78613
512-336-2777 phone
512-336-2778 fax

Patient Name_____ Date of Birth_____

Address_____ Soc. Sec. No._____

City_____ State_____ Zip_____ Telephone #_____

I authorize that my medical records be released TO: **From:**

Name _____ Name Cedar Park Pediatric & Family Medicine

Address_____ Address 345 Cypress Creek Road, Suite 104

City/State/Zip_____ City/State/Zip Cedar Park, TX 78613

Phone_____ Fax_____

Please Release the following information:

___Progress Notes
___History and Physical
___Immunizations
___Other

___X-Rays Reports
___EKG Reports
___Lab Reports
___HIV/AIDS Test

Date of Service_____

This information is necessary for the following purpose:

___Continued Patient Care ___Personal Use __Attorney/Legal
___Insurance ___Other (specify)_____

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty days from the date of the signature or as otherwise specified. _____

REQUESTS TO RECEIVE MEDICAL RECORDS ARE PROCESSED AS A COURTESY. IF RECORDS HAVE NOT BEEN RECEIVED AFTER TWO MONTHS. PATIENT WILL NEED TO CONTACT PREVIOUS DOCTOR.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness