South Austin Medical Clinic, P.A. AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby request and authorize South Austin Medical Clinic to release or obtain information described below

Phone: 512 892 6600 Fax: 512 892 6609

2555 Western Trails Blvd., Ste. 101; Austin, TX 78745

Please DO NOT fax records if more than 10 pages

from the medical records of: XXX-XX-Social Security Number *Current Phone # *Patient Name *Date of Birth Address: Release records To:_____ Obtain records From: Address & Phone # Address & Phone # All records requested by patient will be given on a CD or transfer by fax to new primary physician. If records are to be printed the fee is \$6.50 for the first 20 pages and \$.50 per page thereafter. **Select One: SELECTED INFORMATION to be released:** ____ALL RECORDS will be sent <u>EXCEPT</u> those initialed: ____Sexually Transmitted diseases (to include HIV) _History & Physical ____Alcohol/drug related (including rehabilitation Consultations Laboratory programs) Mental health (including psychology, psychiatry) **EKG** X-Rav Progress Notes **Specific dates of treatment:** Article 4495b; Section 5.08(j) Texas Revised Civil Statutes requires that an authorization for release Of records include "the reason or purpose for the Other release" **Records relating to this condition:** I am transferring my complete medical record Injury: _____ and am terminating my patient status from the releasing physician(s). Reason Accident: The Texas State Board of Medical Examiners approves an initial fee of \$25.00 for the *first 20 pages of a record and \$.50 per page thereafter. These fees apply if an attorney, insurance carrier or third party on you behalf request copies. Fifteen days should be allowed for our office to provide these records after a signed authorization and payment has been received. The fee cost for the release of medical records directly to a patient is \$6.50. I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. I understand that in any event this authorization expires automatically in ninety days fro the date of this signature. The fee is waived if the records are used to support an application for disability or benefits under: AFDC, Medicare, Medicaid, Social Security Administration or Federal Old age Survivors Insurance. I have attached a statement which confirms that an application or appeal has been filed or in pending. The patient agrees that a photocopy, CD or fax copy authorization and records may be considered valid. Signature Date Representative or personal legally authorized to sign. **Relationship to Patient**