Austin Pediatric Surgery

Austin Office-1301 Barbara Jordan Blvd., Suite 400, Austin, TX 78723
North Office-9010 North Lake Creek Pkwy, Bldg2, Suite 303, Austin, TX 78717
Phone (512)708-1234 Fax (512) 708-4567

Dear Dr. ______________________________:

Patient Name: ____ DOB: ___________________________

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. Now, I am requesting the following:

_______ Complete record

_______ Records of care from _______________ to ____________ only

_______ Records of care concerning the following condition(s) ____

_______ Other - Specify: ____

_______ Confer with other person orally about information in my medical record

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 ____________ ___

To the following person(s):

____

Name

____

Street

____Fax #:______________________________

City State ZIP

The reasons or purposes for this release of information are:

____

I understand that you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information.

____ The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed: ____ Date: _______________________
(Patient or person legally responsible to consent on patient's behalf)