

I, the undersigned, do hereby request and authorize South Austin Medical Clinic to release information described below from the medical records of:

_____ Patient Name	_____ Date of Birth	_____ Social Security Number
_____ Address	_____ Phone:	_____ Alternative #
_____ Release records to:	_____ From:	
_____ Address & Phone:	_____	_____

_____**ALL RECORDS** will be sent **EXCEPT** those initialed:
 _____ Sexually Transmitted diseases (to include HIV)
 _____ Alcohol/drug related (including rehabilitation programs)
 _____ Mental health (including psychology, psychiatry)

SELECTED INFORMATION to be released:
 _____ History & Physical
 _____ Consultations
 _____ Laboratory
 _____ EKG
 _____ X-Ray (\$8.00 charge for copies)
 _____ Progress Notes
 _____ Specific dates of treatment:
 _____ Other _____

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 release."

_____**Records relating to this condition:**

_____**I am transferring my complete medical record and am terminating my patient status form the releasing physician(s). Reason**

Illness: _____

Injury: _____

Accident: _____

The Texas State Board of Medical Examiners approves an initial fee of \$25.00 for the first 25 pages of a record and \$.50per page thereafter. These fees apply if you, an attorney, insurance carrier, a new doctor 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.

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 or fax copy authorization and records may be considered valid.

_____ Signature	_____ Date
_____ Representative or personal legally authorized to sign.	_____ Relationship to Patient