Austin Pediatric Surgery
Austin Office - 1301 Barbara Jordan Blvd. Ste 400, Austin, TX 78723
Cedar Park Office – 1301 Medical Parkway, Suite 340, Cedar Park, TX 78613
Phone 512.708.1234 Fax 512.708.4567

Dear Dr. _____:

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

Patient Name: _____**DOB**_____

_____ 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

to the following person(s):

_____
Name

_____
Street

_____
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 authorized to consent on patient's behalf)