

Austin Medical Associates

900 E. 30th St., Suite 100 * Austin, TX 78705
Office Phone (512) 477-1405 * Fax (512) 477-1220

Jerry Vandel, M.D. * Steven Booton, M.D. * Mousumi Chanda-Kim, M.D. * Sophie Hunt, PA-C

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

SS#: _____ Daytime Phone: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

From: _____

To: _____

Ph#: _____

Ph#: _____

Fax#: _____

Fax#: _____

(Previous Doctor)

(New Doctor)

Limitations on the information you may release subject to this Release Form are as follow:

The reasons or purposes for this release of information are as follows:

Patient Signature (parent, guardian or legal representative):

_____ Date: _____

I understand that you will provide this information within 15 day from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.