PRIMARY CARE
KEEPING AUSTIN HEALTHY

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION
TO ATX PRIMARY CARE

Patient Name:_____ Patient Date of Birth:_____

I Hereby Authorize Release of Information from:

1. _____
   Provider/Practice Name Address Phone # Fax#
2. _____
   Provider/Practice Name Address Phone # Fax#
3. _____
   Provider/Practice Name Address Phone # Fax#

Specific Date(s) of Services Requested: _____

Medical Records to be Released: (Check all that apply)

☐History & Physical ☐Progress Notes ☐Lab Results ☐Radiology Reports

☐Immunization Record ☐Consultations ☐Entire Medical Record ☐Other:_____

This information may be sent to and used by the following individual or facility:

ATX Primary Care
Robert Raley, MD Aline C. Zeringue, ACNS-BC
Mandy Mishra, ACNS-BC Sally Reese, APRN, FNP-C, PMHNP-BC
2301 W. North Loop Blvd.
Austin, TX 78756
(P) 512-452-2506 (F) 512-371-0187

I authorize the release of medical records to ATX Primary Care. This authorization expires 90 days from the date of signature.

_____ _____
Patient Signature/Patient Representative Date