ATX PRIMARY CARE
KEEPING AUSTIN HEALTHY

Robert C. Raley, MD
Aline C. Zeringue, RN, ACNS-BC
Eileen M. Costa, APRN, FNP-C
Belinda Read, AGCNS-BC

# AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION **FROM ATX PRIMARY CARE**

I hereby authorize ATX Primary Care/ Robert C. Raley, MD, Aline C. Zeringue, ACNS-BC, Eileen M. Costa, FNP-C & Belinda Read, AGCNS- BC to release the information specified to the provider or medical practice listed below:

Patient Name:_____ Patient Date of Birth:_____

_____ _____
Provider/Practice Name Phone #

_____
Mailing Address

_____
Fax #

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

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

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

Specific Date(s) of services may be requested: _____

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

_____ _____
Patient Signature/Patient Representative Signature Date

_____
Printed Name of Patient/Patient Representative