BEE CAVES PEDIATRICS, PA
2499 S CAPITAL OF TEXAS HIGHWAY
BUILDING B, STE 100
AUSTIN, TX 78746
(512) 328-7666 FAX (512) 328-3547

I hearby authorize the following information to be released from the medical record of:

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

This information is to be released to:

Business/Name _____

Address _____

City _____ State _____ Zip Code _____

Phone # (____) _____

Please check information to be released:

_____ Progress Notes

_____ Immunization Records

_____ Lab Reports

_____ Medical Records from other Providers

Purpose of disclosure:

_____ Attorney/Legal
_____ Commercial Ins.
_____ Worker's Comp.
_____ Continued Care
_____ Personal Use
_____ Other (specify) _____

THERE IS A $25.00 CHARGE PER PATIENT AND MUST BE PAID AT THE TIME OF YOUR REQUEST. PLEASE MAKE CHECKS PAYABLE TO BEE CAVES PEDIATRICS.

_____ _____

Signature of Patient or Legal Representative Date