

Hill Country Pediatrics, P.A.  
Authorization of Medical Record Information

6618 Sitio Del Rio #A101

Austin, TX 78730

Phone: 512-241-1370 Fax: 512-241-1374

Dear Parents,

We will provide one copy of a summary of your Child's visits to include immunization history, growth charts, and labs, x-ray results, and consult letters free of charge. A set of records to include all of the above plus progress notes and office visit notes can be provided to you as a parent for a minimum charge of \$ 20. The ENTIRE medical record can be forwarded to your new physician at **NO CHARGE** to you. By signing this medical release you understand that the information in the patient's medical record may contain information regarding communicable disease including Acquired immunodeficiency Disorders (AIDS) or HIV infection, mental health, alcohol or substance abuse and any related information.

Patient's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

I authorize:

To send information to:

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone/Fax \_\_\_\_\_

Phone/Fax \_\_\_\_\_

Please check records needed:

Immunization Records \_\_\_\_\_

Progress Notes \_\_\_\_\_

Lab/ X-Ray Reports \_\_\_\_\_

Growth Charts \_\_\_\_\_

Consultant Letters \_\_\_\_\_

Entire Medical Record \_\_\_\_\_

Disclosure is for the following purpose:

Continuing Care \_\_\_\_\_

Second Opinion \_\_\_\_\_

Consultation \_\_\_\_\_

Insurance \_\_\_\_\_

Legal Purposes \_\_\_\_\_

Personal Use \_\_\_\_\_

I understand that this authorization is voluntary, and I may refuse to sign this authorization. I understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I have the right to inspect or copy the information to be disclosed. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand Hill Country Pediatrics, P.A. may charge a fee for this service, and by law has thirty days to send medical records after this form is received. This authorization will expire by law 180 days from the date of this authorization unless I specify otherwise.

Signature of Patient or Representative \_\_\_\_\_

Printed Name/ Relationship \_\_\_\_\_

Date \_\_\_\_\_