Payment is required *prior* to copying records. (Texas Administrative Code Rule §165.2)

Lake Austin Pediatrics
Angelyn L. Tarrant, M.D.

6836 Bee Caves Suite 180
Austin, TX 78746

Phone: (512)328-2333
Fax: (512)328-2359

Medical Release

Patient's Name ____ **DOB:** ______________
____ **DOB:** ______________
____ **DOB:** ______________
____ **DOB:** ______________

Dr. Office to PROVIDE information:
Lake Austin Pediatrics
6836 Bee Caves Rd. #180
Austin, TX 78746

Dr. Office to RECEIVE Information:
____
____
____

Information Requested:
____ Immunizations **____ Progress Notes** **____All medical records**
____ Growth Chart **____ Labs**

1) I understand that this authorization will expire in 1 year.
2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying **Lake Austin Pediatrics** in writing.
3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable)
4) I may inspect or copy any information used or disclosed under this agreement.
5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

____ ____________________
Parent's Signature or Patient's Representative **Date**

____ ____________________
Printed Name **Relationship to patient**

YOU HAVE A RIGHT TO RECEIVE A COPY OF THIS FORM.
HIPAA Authorization for use/Disclosure of Protected Health Information
This form does not constitute legal advice and covers only federal, not state, laws.