# BEE CAVES PEDIATRICS

2499 S. CAPITAL OF TEXAS HIGHWAY * BLDG B-100 * AUSTIN, TX 78746
(512) 328-7666-P (512) 328-3547-F

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

_____ All Records

_____ 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 MUST BE PAID AT THE TIME OF YOUR REQUEST. PLEASE ALLOW 10-14 BUSINESS DAYS FOR YOUR RECORDS TO BE PROCESSED.**

______________________________________ ________________

**Signature of Patient or Legal Representative** **Date**