



## Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Information Released to:

Women Partners in Health  
1305 W. 34<sup>th</sup>, Suite 308  
Austin, TX 78705  
Phone (512) 459-8082  
Fax (512) 458-5446

Release from:

Doctor/Medical Office \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Please release:

All Records	History & Physical	X-Ray Reports	ECG Reports
Immunizations	Mental Health	Drug/Alcohol	Lab Reports
Operative Report	Only the following _____		

The information is necessary for the following purpose:

Changing physicians	Personal Use	Attorney/Legal
Insurance	Other (specify) _____	

Signature of patient or legal representative \_\_\_\_\_

Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_