Authorization to Release Medical Records

I, the undersigned, do hereby authorize

Dr. ____________________ Phone: ____________________ Fax: ____________________
to release confidential health information about me from the medical record of:

Patient Name: ______________________________ Date of Birth: ____________________
SS#: ______________________________ Daytime Phone: ____________________

To: Steven K. Booton, MD, FACP
INTERNAL MEDICINE
720 W. 34th St., Suite 100, Austin, TX 78705
P (512) 381-5599 F (512) 323-0307 www.SBootonMD.com

Information to be: ☐ Given to: ☐ Mailed to: ☐ Faxed to:

- ☐ Progress Notes
- ☐ Laboratory Report(s) ____________________
- ☐ History & Physical
- ☐ All of the Above
- ☐ Pathology Report(s) ____________________
- ☐ Consultation Notes
- ☐ HIV/AIDS Information
- ☐ Other: ____________________

Reason for Release of Information

☐ Application for Insurance Claim or Coverage ☐ Changing doctors ☐ Other: ____________________

(Article 4495b, Section 5.08 (j) Texas Revised Civil Statutes requires that an authorization for release of medical records include “the reasons or purposes for the release.”)

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization expires automatically ninety (90) days from the date of signature. I also understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Texas State Board of Medical Examiners.

______________________________ ______________________________
Signature of Patient or Personal/Legal Representative | Printed Name of Patient or Personal/Legal Representative

______________________________ ______________________________
Relationship to Patient | Witness

______________________________ ______________________________
Reason Patient is Unable to Sign | **DATE**

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