

NORTH AUSTIN PEDIATRICS, P.A.

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Cedar Park, TX 78613
(512) 259-0900
Fax: (512) 259-0949

Medical Release of Information Form

By signing this form, I authorize **North Austin Pediatrics, P.A.** to obtain a copy of the specific health information described:

- immunization records
- x-ray reports
- entire chart
- growth chart
- consults _____
- other: _____
- problem list
- lab results

Name of Patient: _____ Date of Birth: _____

Obtain records from: _____

Address: _____

Phone: _____ Fax: _____

Please send records to: _____ 12201 Renfert Way, Suite 110
Austin, TX 78758
Fax (512) 491-8521

or

_____ 1401-B Medical Parkway, Suite 100
Cedar Park, TX 78613
Fax (512) 259-0949

Unless otherwise revoked, this authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary.

Signed By: _____ Date: _____

Relationship to Patient: _____