AUTHORIZATION TO RELEASE INFORMATION

Patient Name:_____ **Date of Birth:**____/___/___

I hereby authorize Avicenna Medical Center to obtain the health information indicated below that is contained in my patient records.

☐ Entire medical records ☐ Emergency Room Records ☐ Immunization records ☐ Medications
☐ Laboratory test results ☐ Entire medical record with the following exceptions:
_____
☐ Only these items from the medical record: (include range of dates):
_____

Name and address of records recipient:

☐ Avicenna Medical Center
709 Bagdad Rd.
Leander, TX 78641
Tel. (512) 260-0101
Fax (512) 260-0121

☐ Will Pick Up

Name of Healthcare Facility from which records are requested

☐_____

Address: _____

City: _____ State:_____Zip:_____

Phone: _____ Fax: _____

_____
Parent or Legal Guardian (Please Print) / Relationship

_____ _____
Parent or Legal Guardian (Signature) Date