TO: ______________________________
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize the medical provider named above to release (by return mail, FAX, or other means of delivery) medical records, x-rays, and any other information in its possession pertaining to my:

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TEXAS ORTHOPEDICS, SPORTS AND REHABILITATION ASSOCIATES

Physician: ______________________________ at

☐ Northwest Austin
4700 Seton Center Pkwy., Ste. 200
Austin, TX. 78759
(512) 439-1000
FAX: (512) 439-1019

☐ Central Austin
911 West 38th Street, Ste. 300
Austin, Texas 78705
(512) 439-1002
FAX: (512) 439-1970

☐ South Austin
3755 Cap of Tx Hwy. South, Ste. 160
Austin, TX. 78704
(512) 439-1005
FAX: (512) 439-1151

☐ Cedar Park
1401 Medical Pkwy. B, Ste. 120
Cedar Park, TX. 78613
(512) 439-1009
FAX: (512) 439-1145

☐ Round Rock
2120 North Mays Street, Ste. 100
Round Rock, TX 78664
(512) 439-1004
FAX: (512) 341-0550

☐ Marble Falls
1701 US Hwy. 281
Marble Falls, TX 78654
(512) 439-1000
FAX: (512) 439-1019

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

__ **Yes**, I consent to the release of this information.

__ **No**, I do not consent to the release of this information.

I also hereby authorize that a photocopy of this authorization be accepted with the same authority as the original. The information disclosed will be used for the purpose of continuity of care.
This authorization is subject to revocation by me at any time. In the absence of prior revocation by me, this authorization will automatically expire in one year.

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Signature of Patient
(or Guardian, if minor)

____
Name of Patient

____
Patient's Date of Birth

Witness: ______________________________

Date: ______________________________