Texas Integrative Medicine

Authorization for Release of

Medical Records

Patient Information (Please Print):

Name:____DOB:_________________

Address:____

City:______________________________State:__________Zip:___________Phone:___________

Please Release My Medical Records From:

Texas Integrative Medicine

4107 Medical Parkway Suite 100

Austin, TX 78756-3735

FAX: 512-367-5975 Phone: 512-420-9300

Email: info@texasintegrative.com

To:

Name: ____

Address: ____

City: ____________________ State: ______ Zip: ________

Phone: __________________ Fax: ____________________

Please send medical records no later than:___________________________________

Please Include:

- ☐ History and Physical
- ☐ Imaging Test Reports
- ☐ Lab Test Reports
- ☐ NeuroSensory Test Reports
- ☐ Progress Notes

BY MY SIGNATURE, I AUTHORIZE THE RELEASE OF MEDICAL RECORDS

____ **Date:**____________________

Patient (or Legal Guardian)