



Authorization for Release of Medical Record Information

Name: _____ DOB: _____
Previous Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize:

**Cedar Park Women's Center
1401 Medical Parkway B, Suite 410
Cedar Park, TX 78613
Fax: 512.260.3911**

**Dr. Jennifer Meadows
Ph: 512.260.3636**

**Dr. Mikaela Rush
Ph: 512.260.9191**

To disclose information from (my / minor child) medical records to:

Physician Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

This information is needed for the following reasons: _____

The specific information I wish to have released is (include dates of treatment):

- | | |
|--------------------------|------------------------|
| Entire Medical Record | Entire Prenatal Record |
| Labs/Pap Smears/Biopsies | Operative Reports |

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed.

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. Separate consent must be given before this information can be released. Please check one:

- I DO consent to have information disclosed
- I DO NOT consent to have information disclosed

This medical record may contain information concerning HIV and/or AIDS diagnosis treatment. Separate consent must be given before information can be released.

Please check one:

- I DO consent to have information disclosed
- I DO NOT consent to have information disclosed

Signature (Parent/Legal Guardian if Minor)

Date