



Authorization for Release of Medical Records to
Margolin, Keinarth & Alberda, M.D.
5222 Burnet Rd., Ste. 200 Austin, TX 78756
Phone: (512) 459-9889 Fax: (512) 389-2935

Patient Information:

Name: _____ **DOB:** _____

Address: _____ **Phone:** _____

Choose one:

Mail Copies

Fax Copies

Purpose of Request:

Continuing Care Other (Explain) _____

Personal Transfer

Release Information from:

Name/Facility: _____

Address: _____

Phone: _____ **Fax:** _____

Information to be Released:

Please provide a 2-year abstract (includes 5 years of labs, radiology, and diagnostics)

Please provide my entire record for dates:
 From: _____ To: _____

Please provide only the following records:
 ___ Progress/Consult Notes ___ Labs ___ Radiology ___ Pathology

Dates of Service: _____

I	<input type="checkbox"/>	DO	DO NOT	<input type="checkbox"/>	want Psychiatric Treatment Notes released
I	<input type="checkbox"/>	DO	DO NOT	<input type="checkbox"/>	want information about my Mental Health released
I	<input type="checkbox"/>	DO	DO NOT	<input type="checkbox"/>	want information about Alcohol and/or Substance Abuse released
I	<input type="checkbox"/>	DO	DO NOT	<input type="checkbox"/>	want information about HIV Tests & Related Information released
I	<input type="checkbox"/>	DO	DO NOT	<input type="checkbox"/>	want information about _____ released

 Patient Signature

 Parent/Legally Recognized Representative Signature

 Witness Signature