

1510 W 34th Street St. 100 Austin TX 78703
505 W Louis Henna Blvd St 200 Austin TX 78728
P: (512) 522-9902 F: (512) 533-9901
Ned Snyder IV, MD

MEDICAL RECORDS REQUEST

Patient Information:	Name (Legal/Maiden/Other) _____ Address _____ City _____ State ____ Zip _____ phone # _____ Date of Birth _____ Social Security Number (optional) _____
Provider / Organization (who is authorized to release the information)	Provider Name _____ Address _____ City _____ State ____ Zip _____ Phone # _____ Fax # _____
Requestor: (Where do you want the records sent?)	Requestor Name _____ Address _____ City _____ State ___ Zip _____ Phone # _____ Fax # _____
Information Requested: *Charges may apply*	Service Dates _____ Entire Record ___ Lab/Radiology Report ___
Purpose of Release:	(Check all that apply) Continuation of care ___ Insurance Coverage ___ Legal ___ SSI/Disability ___ Personal Use ___ Other ___
Requested format:	Mail ___ Fax ___

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I authorize the release of the information listed below, which requires specific consent under federal law: (Check all that apply)

Substance Abuse _____ Mental Health Treatment _____ HIV/AIDS related information _____

Right to revocation.
I have a right to revoke this authorization in writing except to the extent that action has been taken in reliance on this authorization. Your provider must receive the revocation in writing and the written revocation must include:

a. My name and address,
b. The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c. My desire to revoke this authorization, and
d. The date of the revocation, and my signature.

I fully understand and accept the terms of this authorization.

_____ _____ _____
Signature of Patient or Authorized Representative | Printed Name / Relationship to Patient | Date