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# Cedar Park Pediatric & Family Medicine

345 Cypress Creek Road # 104  
Cedar Park, TX 78613  
512-336-2777 phone  
512-336-2778 fax

Patient Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Address \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_

**I authorize that my medical records be released TO:**

**From:**

Name: Cedar Park Pediatric & Family Medicine Name \_\_\_\_\_

Address: 345 Cypress Creek Road, Suite 104 Address \_\_\_\_\_

City/State/Zip Cedar Park, TX 78613 City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Please Release the following information:

Progress Notes  
 History and Physical  
 Immunizations  
 Other

X-Rays Reports  
 EKG Reports  
 Lab Reports  
 HIV/AIDS Test

Date of Service \_\_\_\_\_

This information is necessary for the following purpose:

Continued Patient Care       Personal Use       Attorney/Legal  
 Insurance       Other (specify) \_\_\_\_\_

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty days from the date of the signature or as otherwise specified. \_\_\_\_\_

**\*REQUESTS TO RECEIVE MEDICAL RECORDS ARE PROCESSED AS A COURTESY. IF RECORDS HAVE NOT BEEN RECEIVED AFTER TWO MONTHS. PATIENT WILL NEED TO CONTACT PREVIOUS DOCTOR.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness