

Brent Cardwell, M.D.
Cameron King, M.D.
Joseph Orgeron, M.D.
Jennifer Cardwell, M.D.
Betzi Mathew, M.D.
Carrie Danner, M.D.
Lisa Hutchins, M.D.
Lee Keegan, M.D.



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 _____
Address _____
City/State/Zip _____

Name Cedar Park Pediatric & Family Medicine
Address 345 Cypress Creek Road, Suite 104
City/State/Zip Cedar Park, TX 78613
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