PREMIER
FAMILY
PHYSICIANS

4534 Westgate Blvd, Ste 108 Austin, TX 78745	12600 Hill Country Blvd., Ste R-103 Austin, TX 78738	5625 Eiger Rd., Ste 200 Austin, TX 78735	912 Capital of Tx Hwy South., Ste 100 Austin, TX 78746	104 W. Mercer St., Ste H Dripping Springs, TX 78620

CONSENT FOR RELEASE OF INFORMATION

Patient Name:_____Date of Birth:_____

Cell Phone#:_____Email:_____

Please check the sections that apply, then sign at the bottom of the page:

_____**I do not give PFP permission** to release my information to anyone other than myself.

or

_____**I give PFP permission** to release my information that includes:

_____Entire Medical Record

_____Blood Tests

_____X-rays

_____Cultures, including throat, urine and genital

_____Appointment Details

_____Billing Information

with

_____My spouse or significant other (Name _____)

_____Other family member (Name _____)

_____On home answering machine or cell phone # _____

_____On office/work voice mail # _____

I also give permission to receive all information by mail to address:

_____

_____

Signature:_____ Date:_____

(A signature is required for this form to be considered valid)