



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)