Elgin Pediatrics
Karen English, MD

Authorization to Release Medical Information

_______ I hereby authorize Dr. Karen English to release information **to**:

Name:____

Address:____

Phone_______________________________________ Fax__________________________________

Purpose for this request: (check one)

_____Transfer of Care _____Personal Records _____Attorney/Legal

_____Insurance Coverage _____Other_________________________________

______ I hereby authorize the release of information to Dr. Karen English

Release information **from**:

Name:____

Address:____

Phone:_______________________________________ Fax:_________________________________

Please release the following information:

___________History and physical _________Operative Reports

___________Progress Notes _________Pathology Reports

___________Lab Reports _________Entire Medical Record

___________X-ray Reports _________Other

Purpose: _____Continue patient care _____Attorney/Legal _____Personal

I understand that the information released is for specific purposes stated above. Any other use of this information without the written consent of the patient is prohibited. This consent will expire 90 days after the date of signature unless otherwise specified.

____________________________________/____________________ ___________

Signature Relationship to Patient Date

218 W US Hwy 290, Elgin, TX 78621 512-281-1900-phone 512-285-4100-fax