PREMIER FAMILY PHYSICIANS

12600 Hill Country Blvd Ste R-103 Austin, TX 78738	101 Medical Parkway Ste 210 Austin, TX 78738	5625 Eiger Rd Ste 200 Austin, TX 78735	912 S Capital of Tx Hwy Ste 100 Austin, TX 78746	170 Benney Ln Ste 200 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:

_____ Entries 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)