Patient Release of Medical Information

Patient Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone Number: ______________________

Date of Birth: ______________________ SS#: N/A

Authorizes: Psychiatric Associates of Austin, PA
Wm. Mark Konyecsni, M.D.
9701 Brodie Lane, Suite 203
Austin TX 78748
Phone: (512) 291-1711 Fax: (512) 291-1488

_____ To Release Records To: AND/OR _____ To Receive Records From:

Name of Person or Facility: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone Number: ______________________ Fax Number: ______________________

Type of Medical Records to be Released:
___History ___Progress Notes ___Lab Reports ___Other (______________) ___All Records

Between the dates of______________ & ______________ OR ___ All Dates of Service
Purpose for Release of Medical Records:
___Continuation of Medical Care ___Legal ___Insurance ___Other(______________)

The patient agrees that a photocopy or facsimile of this authorization will be as valid as the original.

Patient Signature______________________________ Date: ______________________