ORTHOPAEDIC ASSOCIATES
OF CENTRAL TEXAS
Ph. 512-244-0766 • Fax 512-244-1013
www.oactdocs.com

AUSTIN BONE & JOINT CLINIC
Phone 512-477-6341 · Fax 512-477-1148
www.abjortho.com

GAO
GREATER AUSTIN ORTHOPAEDICS
Phone 512-401-8400 · Fax 512-441-6388
www.gaortho.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT IDENTIFICATION

Patient Name _____ Date of Birth _____

Address _____

City, State, Zip _____

Telephone No. _____ Social Security No. _____

I request and authorize Orthopaedic Associates of Central Texas/Austin Bone & Joint Clinic to release medical information of the patient named above.

RELEASE RECORDS TO: (where records should be sent) ☐ Fax ☐ Mail ☐ Pick up in person

Same address as above

Name/Agency _____

Address, City, State, Zip _____

Phone Number _____ Fax Number _____

RELEASE RECORDS FROM:

Name/Agency _____

Address, City, State, Zip _____

Phone Number _____ Fax Number _____

MEDICAL RECORDS TO INCLUDE

Dates of Treatment to be Released: _____ to _____

- ☐ History and Physical Exam
- ☐ Consultations
- ☐ Medications
- ☐ Progress Notes
- ☐ X-Ray Copies**
- ☐ MRI Copy**
- ☐ Other (specify) _____
- ☐ All Records

** All imaging on CD only, $10 fee to be paid at time of record request

PURPOSE OF RELEASE

- ☐ Patient Care
- ☐ Personal Use
- ☐ Administrative (i.e. FMLA)
- ☐ Military
- ☐ Appointment sharing with other healthcare provider
- ☐ Disability/Insurance Application/Claim
- ☐ Attorney/Legal Case
- ☐ Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. Medical Practice Act 159.006 - Upon receipt of a proper written request, **the office has 15 business days to release a copy of the medical records.** TSBME Rules 165.2(b)- The requested copies of records shall be furnished by the office within 15 business days after the date of the receipt of the request.
4. I understand that my medical records may contain copies of information received from other healthcare facilities and due to Federal Regulations those records must be released from the original medical facility and not from Orthopaedic Associates of Central Texas.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

ORTHOPAEDIC ASSOCIATES
OF CENTRAL TEXAS

North Austin - OACT
12309 N. Mopac Expy.
Suite 150
Austin, TX 78758

Round Rock - OACT
16020 Park Valley Dr.
Round Rock, TX 78681

Cedar Park - OACT
1401 Medical Parkway
Building C, Suite 100
Cedar Park, TX 78613

Forest Creek - OACT
4112 Links Lane
Suite 101
Round Rock, TX 78664

GAO
GREATER AUSTIN
ORTHOPAEDICS

Lockhart - GAO
1009 San Antonio St.
Lockhart, TX 78644

South Austin - GAO
5625 Eiger Rd.
Suite 175
Austin, TX 78735

James Casey St. - GAO
4310 James Casey St.
Suite 3-C
Austin, TX 78745

AUSTIN
BONE &
JOINT
CLINIC

South Austin - ABJ
5625 Eiger Rd.
Suite 175
Austin, TX 78735

Austin - ABJ
1015 East 32nd Street
Suite 101
Austin, TX 78705

LaGrange - ABJ
657 E. Travis Street
Suite C
LaGrange, TX 78945