Reavis Rehab
& Wellness Center

1201 South IH 35, Suite 105 • Round Rock, Texas 78664
(512) 310-POOL (7665) • Fax (512) 310-9228

Patient Name: _____ Date of Birth: _____

I hereby authorize _____ to release
(Name of clinic/facility/person/organization to release information)

information from the medical record of _____ , specifically,
(Name of patient)

___ Patient Demographic Information and Insurance
___ History and Physical
___ Progress Notes
___ Discharge Summary
___ Evaluation
___School Records
___ Other (Describe):_____

___ Doctor's orders
___ X-ray Reports
___ All Therapy Notes
___ Report of consultation
___ Entire Record

to: _____
(Name of clinic/facility/person/organization to release information to)

The above information is released for the following purpose.
_____
_____
_____
_____
(Give purpose for disclosure of records)

_____ _____
Date Signed Patient's signature or authorized party

If Authorized Party, relation_____

_____