Lisa L. Savage, M.D., P.A.
Gynecology
6818 Austin Center Blvd., Suite 207
Austin, TX 78731
(512) 482-8831

(512)482-8453

Authorization to Release Medical Records

Patient Name_____**DOB:**_____

This letter will authorize you to provide a copy, summary or narrative of my medical records (as indicated by the checkmark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

_____Complete records

_____Records of care from_____to _____only

_____Records of care concerning the following conditions(s)

_____

_____Other. Specify:_____

HIV/AIDS I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical record. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Initial_____Date_____

to the following person:

Name:_____**Phone:**_____

Street:_____**Fax:**_____

City:_____**State:**_____**Zip:**_____

The reason or purpose for this release information is:

_____

I understand that you will provide this information within 15 business days from receipt of request.

I understand that there may be a charge of $25.00 for the first 20 pages and 50 cents for each page thereafter. Unless otherwise revoked, this authorization will expired 90 days from date of signature.

Signed:_____Date:_____