

Medical Records Release Authorization

(to have another physician send records to Dr. Caldwell or Dr. Cassels)

TO: _____
(PHYSICIAN NAME)

(ADDRESS)

(CITY, STATE, ZIP CODE)

(PHONE) (FAX)

I hereby request the medical and credit records on:

(PATIENT'S NAME) (DATE OF BIRTH)

For _____
(DATES, ILLNESSES, ALL RECORDS, ETC.)

To be released to:

_____ WILLIAM D. CALDWELL, M.D.

_____ MELODY CASSELS, M.D.

1305 W 34th STREET, SUITE 210
AUSTIN, TEXAS 78705
512-454-0406 Phone
512-454-4380 Fax

The purpose for this request: _____
(STATE PURPOSE, EXAMPLE: MOVING)

(PARENT/GUARDIAN SIGNATURE – OR PATIENT IF OVER AGE 18) (DATE)

(RELATIONSHIP TO PATIENT)

(ADDRESS)

(CITY, STATE, ZIP)

(PHONE)