Medical Records Release Authorization

I hereby authorize and request you to release a complete copy of my medical records to:

Brent Steadman, M.D.

Steadman Pediatrics
1665 Antilley Rd #150
Abilene, TX 79606
Telephone (325) 692-0212
Fax (325) 692-0214

Name of patient: ______________________ Date of Birth: ______________________
Address of Patient: ____

Signature of Patient (if age 18 or older)
or Patient's Designated Representative: ______________________________
Date: ______________________
Print your name ______________________________

The Purpose of disclosure is:

- Change of insurance or physician
- Continuation of care
- Referral
- Other

Name, address, phone, and fax of physicians from whom you are requesting records:

Name: ______________________ Address: ______________________
Phone: ______________________ Fax: ______________________

Name: ______________________ Address: ______________________
Phone: ______________________ Fax: ______________________

Name: ______________________ Address: ______________________
Phone: ______________________ Fax: ______________________