Medical Release Authorization Form

Courtney Dudley, MD

By signing this form, I authorize Wildflower Pediatrics, P.A. to obtain a copy of the specific health information described:

□ immunization records
□ growth chart
□ problem list
□ entire chart
□ other: ___________________________________

□ lab results
□ x-ray / radiology reports
□ well checks
□ sick visits

Name of Patient: _____________________________ Date of Birth: ______________

Obtain records from:

Practice or Provider Name:__________________________
Address: ____
Phone Number: ____________________________________
Fax Number: ______________________________________

Please send records to:

Wildflower Pediatrics, PA
11609 Anderson Mill Road
Austin, TX 78750
512-900-6055
512-900-6056(fax)

Signed By: __________________________________ Date: _________________

Relationship to Patient: _______________________