Michael Garrett, MD

Direct MD Austin

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby authorize to release information from the medical record of:

Patient Name:
Date of Birth:

FROM:

TO: Michael Garrett, MD
Direct MD Austin
5656 Bee Cave Rd. Ste. K201
Austin, TX 78746
Phone: 512-865-4900
Fax: 877-633-7612

Information to be released:

- ☐ All Medical Records
- ☐ Laboratory
- ☐ EKG
- ☐ X-Rays/Imaging
- ☐ HIV/AIDS
- ☐ Consultation
- ☐ Progress Notes
- ☐ H&P & DC Summary
- ☐ Other:

Reason for Release of Information:

- ☐ Change of Physician
- ☐ Continuity of Care
- ☐ New Patient

Other:

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that, in any event, this authorization expires automatically ninety (90) days from the date of signature.

Signature: Date: