



6818 Austin Center Blvd Ste 207, Austin TX 78731
P: (512) 273-7704 | F: (949) 989-8608
www.upperextremityatx.com

REQUEST FOR MEDICAL RECORDS

HIPAA Authorization | 45 CFR §164.508 | Texas Health & Safety Code §241.154

SECTION 1 — PATIENT INFORMATION

Patient Full Legal Name	DOB (MM/DD/YYYY)	Last 4 digits SSN
Phone Number	E-mail Address:	

SECTION 2 — PLEASE RELEASE RECORDS FROM

Provider / Facility Name	
Address	
City	State / ZIP
Phone Number	Fax Number

SECTION 3 — PLEASE SEND RECORDS TO

Upper Extremity ATX — Travis Doering, MD
6818 Austin Center Blvd, Suite 207, Austin, TX 78731
Fax: (949) 989-8608 | Phone: (512) 273-7704 | medical.records@upperextremityatx.com



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SECTION 4 — RECORDS REQUESTED

Date range: All records or From: _____ To: _____

Record types (check all that apply):

<input type="checkbox"/> Office / clinic notes	<input type="checkbox"/> Operative reports	<input type="checkbox"/> Imaging (X-ray, MRI, CT)
<input type="checkbox"/> Lab / pathology results	<input type="checkbox"/> Physical therapy notes	<input type="checkbox"/> Consultation letters
<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Emergency records	<input type="checkbox"/> Entire medical record

Other / specify:

SECTION 5 — PATIENT AUTHORIZATION

I authorize the provider listed in Section 2 to release the records described above to Upper Extremity ATX. I understand that:

- I may revoke this authorization in writing at any time, except where action has already been taken.
- Released records may be re-disclosed and may no longer be protected by HIPAA.
- I may refuse to sign without affecting my treatment or eligibility for services.

Authorization expires: 90 days from signature Upon receipt of records Specific date:

Patient Signature X _____	Date _____
If legal representative — Relationship to patient _____	Representative Printed Name _____



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FOR OFFICE USE ONLY

Date sent: _____

Sent via: Fax Mail Portal

Staff initials: _____

Records received: Yes No Date received: _____

Follow-up needed:
 Yes No

*Questions? Contact medical.records@upperextremityatx.com
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