



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

- I authorize Advanced Pain Care and its sub-specialties to release information from my Medical Record as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Check all that apply to the above names:

- Regarding appointment, time & date
 Discuss medical care, an issue or concern
 Discuss Billing Information

- Discuss Lab Results
 Pick up Prescriptions

- Discuss Imaging Results
 Pick up Forms

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.*

Patient Signature

Date

Legally Authorized Representative

Relationship to Patient

Witness

Date