ADVANCED PAIN CARE

Authorization to Release Medical Records

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of your Medical Records.

Patient Name: _____ DOB: _____

Phone Number: _____ Email Address: _____

RELEASE INFO TO:

Name: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____

Fax: _____

OBTAIN INFO FROM:

Name: _____

Address: _____

City, State: _____ Zip: _____

Phone: _____

Fax: _____

Reason for Disclosure (Please check one):

☐ Treatment/Continuing Care ☐ Personal Use ☐ Billing/Claims

☐ Insurance ☐ Legal Purposes ☐ Disability Determination

☐ School ☐ Unemployment Other: _____

What information can be disclosed? *Complete the following by indicating those items that you want disclosed. If the entire Medical Record is to be released, then check only the first line.*

☐ **Entire Record** ☐ History/Physical Exam ☐ Past/Present Medication ☐ Lab Results

☐ Physicians Orders ☐ Patient Allergies ☐ Operation Reports ☐ Consultations

☐ Progress Notes ☐ Diagnostic Test Reports ☐ Billing Information ☐ Radiology

Your initials are required to NOT release the following information:

☐ Mental Health Records (Excluding Psychotherapy Notes) ☐ Genetic Information/results

☐ Drug, Alcohol, or Substance Abuse Records ☐ HIV/AIDS test results/treatment

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. I understand that Advanced Pain Care will not condition treatment on whether I sign this authorization.*

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.*

This authorization will expire in 1 year from the date of signature unless another date is specified: _____

_____ _____

Patient Signature Date

_____ _____

Legally Authorized Representative Relationship to Patient

_____ _____

Witness Signature Date