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 circle 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 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 <u>NOT</u> 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* ***<u>Advanced Pain Care 2000 S. Mays St., Suite 201 Round Rock, TX 78664</u>***. *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 Signature Date