



Round Rock | South Austin | Central Austin | North Austin | Cedar Park | Georgetown | Waco | Killeen | Amarillo

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Amarillo Phone: (806) 350-7918 | Amarillo Fax: (804) 418-8982

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: _____
 Phone Number: _____

DOB: _____
 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.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medication | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Physicians Orders | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Billing Information | <input type="checkbox"/> Radiology |

Your initials are required to **NOT** release the following information:

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Records (Excluding Psychotherapy Notes) | <input type="checkbox"/> Genetic Information/results |
| <input type="checkbox"/> Drug, Alcohol, or Substance Abuse Records | <input type="checkbox"/> 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: ATTN Medical Records 101 W Louis Henna Blvd, Suite 300, Austin, TX 78728.** 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