



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

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## **AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

Patient Name:	Date of Birth:	
<ul> <li>I authorize Advanced Pain Care to release informati</li> <li>Many of our patients allow family members to call a records, and results of tests, pick up forms, etc. Und information to anyone without the patient's consendembers you must sign this form. Signing this form indicated below.</li> </ul>	and discuss medical informat der the requirements of HIPA at. If you wish to have any of	tion, request prescription refills, medical AA we are not allowed to give this your medical information released to family
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Check all that apply to the above names: Regarding appointment, time & dateDiscuss medical care, an issue or concernDiscuss Billing Information	Discuss Lab Results Pick up Prescriptions	Discuss Imaging ResultsPick 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		
Legally Authorized Representative		ship to Patient
Witness		