

**PAIN SPECIALISTS OF TEXAS AUTHORIZATION FOR
DISCLOSURE OF HEALTH INFORMATION**

I authorize the use or disclosure of the following individual's health information to be released as described below.

Patient Name: _____ Date of Birth: ____/____/____ Phone: _____

Address: _____ City: _____ State: ____ Zip Code: _____

I request the following individual or organization to release the health record.

Entity's Name: _____ Phone number: _____

Address: _____ City: _____ State: ____ Zip Code: _____

The type and amount of information to be used or disclosed is as follows: (include dates if appropriate).

_____ Complete health records	_____ Lab results/X-ray reports
_____ Physical exam	_____ Consultation reports
_____ Daily notes	_____ Other (please specify _____)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

The information as listed about may be disclosed to and used by Pain Specialists of Texas for treatment and care and can forwarded to:

**Pain Specialists of Texas
4927 Lake Ridge Parkway #170
Grand Prairie, Texas 75052**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 6 months from my signature.

I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact: Lynne George, Privacy Officer for Pain Specialists of Texas.

Signature of patient or legal representative _____ **Date** _____

Signature of witness _____ **Date** _____