AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FROM OTHER ENTITIES TO PAIN SPECIALISTS OF TEXAS

Please do not fill out the middle part (entity information), only the top and bottom parts.

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

Patient Name:_____ Date of Birth:_____/_____/19_____

Contact Phone:_____-_____-_____ Address:_____

City:_____ State:_____ Zip Code:_____

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

Entity's Name _____

Telephone Number:_____-_____-_____ Address_____

City_____ State _____ Zip Code_____

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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 above may be disclosed to and used by Pain Specialists of Texas for treatment and care and can be forwarded to

Pain Specialists of Texas
1759 Broad Park Circle South, Suite 101, Mansfield, Texas 76063
Phone: 682-518-0682, Fax: 682-518-1334

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 _____/_____/201___

Signature of witness_____ Date _____/_____/201___