PAIN SPECIALISTS OF TEXAS
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1759 Broad Park Circle South, #101, Mansfield, TX 76063, Phone: 682-518-0682, Fax: 682-518-1334

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

Patient Name:_____ Date of Birth:___/___/_____ Contact Phone:____-____-_____

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

I request **Pain Specialists of Texas** to release my health information as follows:

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

_____ for treatment and care and can be forwarded to:

Entity's Name_____ Telephone Number:_____-_____-_____

Address_____ City_____ State____ Zip Code_____

I understand that I have the 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 12 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 re-disclosure 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___**