Northwest Anesthesiology and Pain Services, PA

HOUSTON PAIN SPECIALISTS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Medical Records Release/Request Form

Patient Name: _____
(Last, First, Middle Initial) (Previous Name)

Address: _____
(Street or PO Box) (City/State) (Zip)

Date of Birth:_____**Telephone:**_____**Social Security# xxx-xx-**_____

Reason of Record Request:

□ Continuation of Care	□ Billing or Claims	□ Disability Determination	□ Other
□ Transferring Care	□ Insurance	□ School	_____
□ Personal Use	□ Legal Purposes	□ Employment	

I hereby authorize **HOUSTON PAIN SPECIALISTS** to **RELEASE MY HEALTH INFORMATION TO:**

_____
(Person or Organization)

_____
(Street Address or PO Box)

_____
(City, State, Zip)

_____ _____
(Telephone Number) (Fax Number)

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want released/disclosed. If all health information is to be released/disclosed, then check ONLY the first box**.**

□ Complete Medical Record - ALL	□ Operative Reports
□ Last 6 Months Records of Active Treatment	□ Psychological Records **SEE BELOW**
□ Office Visits (From_____to_____)	□ Physician Orders
□ Imaging Reports	□ Other (specify) _____
□ Lab Results	

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:
_____ I do___(OR) do not___consent to release information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol/drug abuse and/or HIV testing/results, or such disclosure shall be limited to the following specific types of information: _____.

EFFECTIVE TIME PERIOD: This authorization expires within (6) months from the date signed. If you wish to have the authorization expire before (6) months, please indicate the date of expiration:_____.
RIGHT TO REVOKE: I understand that I can withdrawal my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named as the RECEIPENT of the medical records and to Houston Pain Specialists I understand that prior actions taken in reliance on the authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. It is further understood that the information is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
(Signature of Patient or Legal Representative*) (Date)
**Legal Representative must submit copies of a legal document supporting assignment of this authority.*

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