

## **Authorization for Release of Medical Information**

This will authorize:  To Release to:  Name:  Republic Spine and Pain, PA  Address:  13617 Caldwell Drive ste. 100  City, State, Zip:  Austin, Texas 78750 512-219-8787 512-219-8788 fax  GENERAL INFORMATION REQUESTED  Medical Information Requested:  Complete medical records  Complete medical records  To update my regular doctor (provider)  Lab reports  I have been referred to another doctor  Progress notes, including medication list  My insurance changed  I am heaging doctor (provider)  Dissatisfaction with care  My insurance changed  I am moving (New Address)  Other  SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION  PROTECTED BY STATE ORIEDERAL IAW  I specifically authorize the release of data and information relating to (Note, you must mark yes or no):  Yes No  Mental Health/Depression (includes psychological testing)  Mental Health/Depression (includes	Patient Full Name:	DOB://
This will authorize:    Republic Spine and Pain, PA	Previous/Other Name:	(If different than patient listed
Republic Spine and Pain, PA  Address:    13617 Caldwell Drive ste. 100   City, State, Zip:	above)	
Address:	This will authorize:	To Release to:
City, State, Zip: Austin, Texas 78750	Name:	Republic Spine and Pain, PA
Phone, Fax:	Address:	13617 Caldwell Drive ste. 100
GENERAL INFORMATION REQUESTED  Medical Information Requested:    Complete medical records   To update my regular doctor (provider)     Lab reports   I have been referred to another doctor     Progress notes, including medication list   I want/need a second opinion     Immunization   Dissatisfaction with care     My insurance changed   I am moving (New Address)     Other   SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION     PROTECTED BY STATE OR FEDERAL LAW     I specifically authorize the release of data and information relating to (Note, you must mark yes or no):  Yes No   Substance Abuse (alcohol/drug abuse)     HIV-Related Information (AIDS related testing)     HIV-Related Information (AIDS related testing)     HIV-Related Information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information. RESTRICTIONS:  The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.  Signature of patient or authorized representative: Witness	City, State, Zip:	
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