REPUBLIC Spine & Pain

Authorization for Release of Medical Information

Patient Full Name: _____ **DOB:** __ __/__ __/__ __
Previous/Other Name: _____ **(If different than patient listed above)**

This will authorize:

Name: _____
Address: _____
City, State, Zip: _____
Phone, Fax: _____

To Release to:

Republic Spine and Pain, PA
13617 Caldwell Drive ste. 100
Austin, Texas 78750
512-219-8787
512-219-8788 fax

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- ☐ Complete medical records
- ☐ Lab reports
- ☐ Progress notes, including medication list
- ☐ Immunization
- ☐ Other _____

Reason for Release:

- ☐ To update my regular doctor (provider)
- ☐ I have been referred to another doctor
- ☐ I want/need a second opinion
- ☐ I am changing doctor (provider)
- ☐ 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)
☐	☐	Mental Health/Depression (includes psychological testing)
☐	☐	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information.
Any release of 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
Date: __ __/__ __/__ __ Date: __ __/__ __/__ __