



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:

- | | | | |
|---|--|---|--------------------------------|
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Billing or Claims | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other |
| <input type="checkbox"/> Transferring Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> School | _____ |
| <input type="checkbox"/> Personal Use | <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Employment | |

I hereby authorize North Houston Pain Center, a provider for **Northwest Anesthesiology and Pain Services, PA**, 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.

<input type="checkbox"/> Complete Medical Record - ALL	<input type="checkbox"/> Operative Reports
<input type="checkbox"/> Last 6 Months Records of Active Treatment	<input type="checkbox"/> Psychological Records **SEE BELOW**
<input type="checkbox"/> Office Visits (From _____ to _____)	<input type="checkbox"/> Physician Orders
<input type="checkbox"/> Imaging Reports	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> 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 RECEIPT of the medical records and to North Houston Pain Center 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.*