MEDICAL RECORDS RELEASE FORM

Patient Name **Date of Birth**

Address **Telephone**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Limitations on the information you may release subject to this Release Form are:

1. Last three office visits (if applicable)
2. Radiological reports (both printed and disk images)
3. Lab reports
4.

Release my protected health information to the following person(s) / entity:

Name:	Advanced Spine and Pain Specialists			
Street:	25305 Interstate 45	The Woodlands	TX	77380
Phone:	**(281) 868-7246**	**Fax:**	**(855) 838-6070**	

The reasons or purposes for this release of information are as follows:

1. For evaluation and treatment of patient
2. For continuity of care
3.

Patient Signature (or parent, guardian or legal representative)

X _____ **Date:** _____

Print Name: _____ **DOB:** _____