Please Fax Records to

979-245-2079

MEDICAL RECORD RELEASE FORM

By signing this form, I authorize the release of confidential health information about me

PATIENT NAME: ______________________________ **DOB:** ____________ **SS#** ___________

I request and authorize:

THE PAIN RELIEF CENTER
AJAY AGGARWAL, M.D.
111 Avenue F
Bay City, TX 77414
P: (979) 245-2777 F: (979) 245-2079

to release healthcare information of the patient named above to:

NAME: ____
ADDRESS: ____________________ **CITY** __________ **STATE:** _____ **ZIP:** _______
PHONE: ____________________ **FAX:** ____________________

I authorize the following to be released:

- ☐ ALL HEALTHCARE INFORMATION
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Lab Report(s)
- ☐ Physical Therapy Notes
- ☐ History/Physical
- ☐ Radiology report(s) (MRI, X-ray, CT scans)
- ☐ Other: ______________________________

Pertaining to the following dates of service: From: __________________ To: ____________________ (give dates)

☐ **YES** ☐ **NO** I authorize the release of my STD, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ **YES** ☐ **NO** I authorize the release of any records regarding Drug, Alcohol, or Mental Health treatment to the person(s) listed above.

Purpose or Need for Disclosures: ☐Continued Patient Care ☐Personal Use ☐Insurance Claim ☐Attorney/Legal ☐Other (specify) ______________________

I understand that the information released is for the specific purpose stated above. Any other use if this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified. I also understand that a fee for preparing and furnishing this information may be charged to the requesting patient according to rulings set forth by the Texas State Boards of Medical Examiners.

______________________________ ____________________
Signature of Patient or Legal Representative Date

____
Printed Patient Name