Pain Care Physicians

Release of Medical Information

Patient Name: _____

Address: _____

_____

DOB: _____ SSN: _____ Phone: _____

Persons authorized to assist: _____

I hereby authorize Pain Care Physicians to provide the below mentioned party a copy, summary, or narrative of my medical records and release the following confidential information to:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Release the following information:

☐ Complete Record
☐ Information on the following dates:
_____ to _____

☐ Other: _____
☐ Records concerning the following condition:
_____

Reason for this request:

☐ Continuing Medical Care
☐ Changing Doctor Care
☐ Attorney/Court Review

☐ Worker's Compensation
☐ Personal Records
☐ Other: _____

The patient understands that you will provide this information within 15 business days from the receipt of this request and that a fee for preparing and furnishing this information may be charged to the patient according to rulings set forth by the Texas State Board of Medical Examiners.

Patient Signature: _____ Date: _____