Pain Care Physicians
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fax: (512) 326-8660
www.paincarephysicians.com
Physical Medicine & Rehabilitation/Pain Medicine

Instructions for Release of Information to a Third Party

RE: _____ (account number if known)

Please refer to this account number on all future correspondence)

Your reference number if known:

ATTN: _____ (your preferred contact person)

TO: _____ (title of professional or representative)

FIRM: _____ (requesting authority)

TEL: _____ (include area codes)

FAX: _____ (include area codes)

Dear Representative or Counselor:

Thank you for your recent contact involving a mutual patient/ client. Please be advised that a number of healthcare regulations may apply to communication between your office and our practice. The main office for Pain Care Physicians is located in the city of Austin, Travis County, state of Texas.

Please send us any questions, concerns, or requests for clarification which you may have clearly identified with your signature, on your letterhead including the purpose of such correspondence.

If applicable:

- Please include a signed authorization for release of information with your inquiry from the patient or representative.
- State whether your interests may diverge with the patient's interests.
- Provide the billing address where a fee for records may be sent.

With Regards,
Pain Care Physicians