Release of Medical Information

(Custodian of Medical Records)

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Please release and forward the following information to Pain Care Physicians

Name: _____

Address: _____

_____

DOB: _____ SSN: _____ Phone: _____

Persons authorized to assist: _____

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