Authorization Form for Release and Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____

Address:_____ Social Security:_____

City:_____ State:_____ Zip:_____ Phone:_____

Provider Information:

Name:_____ Phone:_____

Address:_____ Fax:_____

City:_____ State:_____ Zip:_____

I hereby authorize the following doctor or person to release and disclose my protected health information to Dallas Pain Consultants located at 1411 North Beckley Avenue Suite 152 Dallas, TX 75203 via Fax (214) 948-7701:

Please check all that apply to this release and disclosure:

_____ All Medical Records _____ All Financial Records _____ Office Visit Notes

_____ Radiology Records _____ Procedure Notes

_____ Other: _____

This information is being disclosed for the following purpose(s):

_____

I understand that the information in my health record may include information relating to communicable diseases, 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.

Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify an expiration date this authorization will expire by law 180 days from the date of this authorization.

Expiration date, event or condition: _____

I understand that I have the right to revoke this authorization at anytime. I understand that in order to revoke this authorization, I must do so in writing and the written revocation can be delivered or mailed to Dallas Pain Consultants, 1411 N Beckley Ave, Pav. 3, Ste. 152, Dallas, TX 75203 or faxed to 214-948-7701. The revocation does not affect any actions taken before the receipt of the written revocation and does not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once this information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand I will be given a copy of this authorization form, after signing.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient

_____ _____

Signature of Witness Date