AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of your Medical Records.

First Name _____ Last Name _____

Date of Birth _____

Phone Number _____ Email Address _____

Release Information To:	Obtain Information From:
Name: INTEGRATED PAIN ASSOCIATES	Name: _____ _____
Address: 3800 SOUTH WS YOUNG DR SUITE 201	Address: _____
City, State: KILLEEN, TX Zip:76542	City, State: Zip:
Phone: 254-245-9175	Phone:
Fax: 254-213-7771	Fax:

INFORMATION TO BE RELEASED:

Reason for Disclosure:

☐ Continuation of Care for the last 12 months

☐ Other _____

What information can be disclosed? *Complete the following by indicating those items that you want disclosed.*

☐ History / Physical ☐ Exams ☐ Lab Results ☐ Physicians ☐ Orders ☐ Radiology

☐ Operation Reports ☐ Diagnostic Testing Reports ☐ Consultations ☐ Only Records pertaining to pain

Right to Revoke: I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to Integrated Pain Associates.

SIGNATURE AUTHORIZATION: I have read this form and agree to the use and disclosure of the information as described. I understand that refusing to sign this form does not stop release of Medical Records that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154 © and /or 45C.F.R 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

Patient Signature Signature Date

_____ _____

Legally Authorized Representative Signature Date