AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **DOB:**_____
Address: _____ **Phone (H):** _____
_____ **Phone (M):** _____

PLEASE NOTE: COPY FEE MAY BE CHARGES FOR MEDICAL RECORDS

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: INTEGRATED PAIN ASSOCIATES **Facility Phone: (254) 245-9175**
MEDICAL RECORDS DEPARTMENT
Facility Address: 3800 SOUTH WS YOUNG DR, SUITE 301 **Facility Fax: (254) 213-7771**
City/State/Zip: KILLEEN, TX 76542 **Email:MedRecords@ipaclinic.com**

Dates and type of information to disclose:
☐ 2 years prior from date last seen
☐ Specific Dates:
☐ Other Specific information:_____

The purpose of this disclosure is:
☐ Change of insurance or physician
☐ Continuation of care
☐ Referral
☐ Other:_____

RESTRICTIONS: Only medical records originates through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Facility Name: _____ **Facility Phone:** _____
Facility Address: _____ **Facility Fax:** _____
City/State/Zip: _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

If I have read the above foregoing Authorization for release of Information and do hereby acknowledge that I am familiar with and full understand the terms and conditions of this authorization.

_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative **Date**
IF GUARDIAN OR AUTHORZIED REPRESENTATIVE OF PATIENT (must attach documentation of such status)

_____ _____
Printed name of guardian/authorized representative Relationship/Capacity to patient

_____
Address and telephone number of guardian/authorized representative