SPINAL DIAGNOSTICS & THERAPEUTICS
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Authorization for Release and Disclosure of Protected Health Information

In accordance with state law and regulator agency requirements, the health record is the property of Pain Management Consultants, P.A. A pre-payment of $25 may be required before the request can be processed.

I hereby authorize the PMC Medical Records Custodian to release information from the medical record of:

Patient Name: ______________________ SS#: **xxx-xx-_____**

DOB: __ / __ / ____ Phone: ______________________________

To: Pain Management Consultants, P.A.	Information May be Released from:
Name: Pain Management Consultants, P.A.	Name:
Address: 101 West Koenig Lane # 100	Address:
Austin, TX 78751	
Phone: (512) 454-9426	Phone:
Fax: Fax: (512) 454-7294	Fax:

Please release the following information:

_____ Office visits for last 6 months _____ Labs - any obtained within the past year

_____ _Radiology reports for body part: _________________ Other: __________________

This information is necessary for the following purpose:

_____ Continued patient care _____ Personal use _____ Other: ____________________

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

I understand that I have a right to 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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions, I may inspect or copy the information to be used or disclosed. 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 a questions about disclosure of my health information, I can contact the Health Information Management Manager at (512) 406-0182.

With respect to clients receiving chemical dependency services, this information has been disclosed to you from records protected by federal law 42 USCA Sec. 290-dd(2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains or as otherwise permitted by federal law 42 USCA Sec. 290-dd(2).

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Signature of Patient or Legal Representative Date

____

Relationship to Patient Witness