CRPS AND NEUROPATHIC PAIN CENTER OF AMERICA
Phone: 817-714-7710
729 W. Bedford Euless Rd. Suite 206
Hurst, Texas 76053

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____
Date of Birth _____ Social Security # _____ (optional)
I authorize the following individual or organization to disclose the above named individual's health information:
_____ Address: _____
This information may be disclosed TO and used by the following individual or organization:
_____ Address: _____
For the purpose of: _____
Please release the following:

___Problem List ___X-Ray/Imaging Reports-from date_____ to date _____
___Progress Notes ___X-Ray Films
___History/Physical Exam ___Laboratory Results-from date_____ to date _____
___Medication List ___EKG Reports
___Immunization Record ___Other Diagnostic Reports (Specify) _____
___List of Allergies ___Other (Specify) ALL MEDICAL RECORDS

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

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

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 individual or organization releasing information. I understand that the revocation will not apply to information already 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 or condition:

_____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

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 ensure treatment. I understand that I may inspect or copy 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 of my health information, I can contact _____ (insert privacy officer or other office or individuals name or contact information)

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

Date Request Completed _____ # pages copied _____ Reviewed Only _____

Charges $ _____ Cash _____ Check # _____ Initials _____

All Articles and any forms, checklists, guidelines and materials are for generalized information only and should not be used or referred to as primary legal sources, nor construed as establishing medical standards of care. They are intended as resources to be selectively used and always adapted- with the advice of the organization's attorney- to meet state, local, individual organizations and department needs or requirements. It is distributed with the understanding that neither Texas Medical Liability Trust's Risk Management Department nor Texas Medical Liability Trust is engaged in rendering legal services.