

Corporate Office & NW Practice
 9920 Cypresswood Dr.
 Houston, TX 77070
 281-955-5585 (Tel)
 281-955-8508 (Fax)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name _____ DOB _____

SS# _____

Information Released to:
CENTER FOR PAIN RECOVERY, P.A.
TEL 281-955-5585
FAX 281-955-8508

From: _____

Please release the following:

Progress Notes _____ <u>XXX</u>	Diagnostic Reports _____ <u>XXX</u>
History/Physical _____ <u>XXX</u>	Op Reports _____ <u>XXX</u>
Lab Reports _____ <u>XXX</u>	
Other (Specify) _____ <u>XXX</u>	<u>Records for the past one year (if applicable) and medications</u>

Including information (if applicable) pertaining to:
 Mental Health _____ Drug/Alcohol _____ HIV/AIDS _____

Purpose or Need for Disclosure:

Continued Patient Care _____ <u>XX</u>	Personal Use _____
Attorney/Legal _____	Insurance Claim/Application _____
Disability Determination _____	Other (Specify) _____

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 further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

 Signature of Patient or Legal Representative

 Date

 Relationship to Patient

 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 the medical records to prevent my misunderstanding of the information contained in these entries.

I will not hold Dr. Mark Barhorst 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