



9707 Anderson Mill Road
 Suite 230
 Austin, Texas 78750
 512-219-8787
 512-219-8788 fax

Authorization for Release of Medical Information

Patient Full Name: _____ **DOB:** __/__/__

Previous/Other Name: _____ (If different than patient listed above)

This will authorize: *Sending you records elsewhere*

Republic Spine and Pain, PA
9707 Anderson Mill Road
Suite 230
Austin, Texas 78750
512-219-8787
512-219-8788 fax

To Release to:

Name: _____

Address: _____

City, State, Zip: _____

Phone, Fax: _____

GENERAL INFORMATION REQUESTED

Medical Information Requested:

- Complete medical records
- Lab reports
- Progress notes, including medication list
- Immunization
- Other _____

Reason for Release:

- To update my regular doctor (provider)
- I have been referred to another doctor
- I want/need a second opinion
- I am changing doctor (provider)
- Dissatisfaction with care
- My insurance changed
- I am moving (New Address)
- Other _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, you must mark yes or no):

Yes No

- Substance Abuse (alcohol/drug abuse)
- Mental Health/Depression (includes psychological testing)
- HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information.

Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:

The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

 Signature of patient or authorized representative:

Date: __/__/__

 Witness

Date: __/__/__