Frisco Spine
BRAIN & SPINE SURGEONS

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____ Date of Birth: _____

MEDICAL RECORDS TO BE RELEASED **FROM**:

_____

Physician's Name Fax:

_____

Attention: Phone:

PATIENT INFORMATION IS NEEDED FOR:

☐ Continuing Medical Care ☐ Personal Use ☐ Military
☐ Insurance ☐ School
☐ Legal Purposes ☐ Social Security/Disability ☐ Other _____

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History & Physical ☐ Progress Notes ☐ Care Plan ☐ EKG Report
☐ Operative Reports ☐ Lab/Pathology ☐ Consult Report
☐ Discharge Summary ☐ X-ray Reports/Images ☐ ER Record
☐ Face Sheet ☐ Dates of service:_____

MEDICAL RECORDS ARE TO BE SENT **TO**:

_____

Physician's Name Fax:

_____

Attention: Phone:

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

_____ _____

Date Patient or Legally Authorized Representative

_____ _____

Printed Name of Patient or Legally Authorized Representative Relationship to the patient