MEDICAL RECORD RELEASE FORM

THE PURPOSE OF THIS RELEASE IS AT THE REQUEST OF THE PATIENT

Date:_____

Patient Name:_____Date of Birth:_____

Patient Address:_____City,State,Zip:_____

Patient Phone Number:_____

I _____, hereby authorize _____ to release all my medical records to:

Alamo Pain Center
Joseph Gabriel, M.D.
p: (210)654-7246 f: (210)654-7247

The following information is authorized for release:

- ☐ **ALL** Medical Records, including Clinical, Progress, and OP notes
- ☐ Demographics and Insurance Card
- ☐ Lab/Radiology Reports, Diagnostic Films

The following information will not be released unless specifically authorized:

___I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis, or treatment.

___I specifically authorize the release of information pertaining to mental health diagnosis or treatment.

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. This authorization expires one year from the date of signature.

_____ _____
Signature of Patient or Legal Representative Date

_____
Print Name