



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 **Alamo Pain Center, P.A.** to release all my medical records to:

Name: _____

Address: _____

Phone #: _____

Fax #: _____

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

11465 Toepperwein Road
Live Oak, Texas 78233

P: (210)654-7246

F: (210)654-7247