

Authorization For Release of Information

I hereby authorize Texas Back Institute the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ SS#: _____

Phone Number: _____ DOB: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Circle specific item(s) to be released (and insert specific dates below if applicable):

- | | | |
|---|--|---|
| <input type="checkbox"/> All Records* | <input type="checkbox"/> Operative Notes | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Abstract/Summary | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Lab/Path Records |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Billing Records | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Radiology Films (Duplicated films are on CD and not actual film. Duplication of film will require additional Fee.) | | |

***Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.**

These records are for services provided on the following date(s): _____

What is the purpose of this disclosure: _____

Please send the records listed above to (use additional sheets if necessary):

Name: _____ Phone: _____

Address: _____ Fax: _____

- This authorization will expire no on ___/___/___ or at the term of _____. If no date specified this release will expire 180 days from the date signed.
- I understand that I may revoke this authorization at any time by written notification to the providing organization, but if I do it won't have any affect on any actions they took before they received the revocation.
- **I understand that there may be a fee for a copy of this information.**
- I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment: receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

Signature of patient or patient's representative

Date

Printed name of patient's representative

Relationship to patient

Medical Records is Closed Between 12:00 and 1:00 Daily. Fax to 972-608-5018 Attn: Records Release.