



Texas Back Institute

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize 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. This form must be completely filled out.

Patient Name: _____ SSN#: _____

Phone Number: _____ DOB: _____

Email Address: _____

Medical Provider to release records:

Texas Back Institute

____ Plano _____ Denton

____ Trophy Club _____ Ft. Worth

____ Rockwall

Persons/organizations receiving the information:

Circle specific articles of information (and insert specific dates if applicable):

_____ Dates Progress Notes Labs Operative Reports Radiology Report Correspondence

Hospital Records Other Provider Records Test Results Consultations PT Notes Entire Chart

Radiology Films* Billing _____ Other

*** All films will be duplicated digitally using Dicom Software and provided on CD.**

Section B: Must be completed only if a health plan or health care provider has requested the authorization

* Will the health plan or care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ____ yes ____ no

* I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

* I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Further, **I understand there may be a fee for a copy of this information.**

Section C: Must be completed for all authorizations

* What is the purpose of the use or disclosure?: _____

* I understand that this authorization will expire on ____/____/____. Or at the term of _____ event. If not specified, this release will expire 180 days from the date signed.

* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information.

Signature of patient or patient's representative

Date

(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to the patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PLEASE NOTE: MEDICAL RECORDS IS CLOSED BETWEEN 12:00 PM AND 1:00 PM EVERYDAY

PLEASE FAX BACK TO DAVIN AT 972-608-5018