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):

□ All Records*	□ Operative Notes	□ Physical Therapy Notes
□ Abstract/Summary	□ Radiology Reports	□ Lab/Path Records
□ Progress Notes	□ Billing Records	□ Other: _____

□ 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.**