REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of information from the medical record of:

Patient Name ____ DOB __________________________

Information to be released to:

Brazos Pain Management, P.A.
2225 Williams Trace Blvd., Suite 108
Sugar land, TX 77478
Phone: 281-240-4300
Fax: 281-240-4353

From:
____
____
Phone:_____________________________________
Fax :_____________________________________

Please release the following:

Progress Notes _______
History/Physical _______
Lab Reports _______
Other (Specify) _______
Medication History ______
Op Reports _______
Imaging Reports _______
Imaging Films _______

Including information (if applicable) pertaining to: Mental Health ______ Drug/Alcohol _______ HIV/AIDS ________

Purpose or Need for Disclosure: Continued Patient Care ___√____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

____
Signature of Patient or Legal Representative

____
Date

____
Relationship to Patient (if Legal Representative)

____
Witness (if Legal Representative)