|  |  |
| --- | --- |
| https://txppprapp.ecwcloud.com/mobiledoc/jsp/catalog/xml/logo.JPG | **Pyramid Pain & Rehab PA** 1001 Sara Swamy Drive Ste 220      Sherman TX 75090-3124 Ph: 903-892-1999  Fax:903-892-6999 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **I authorize the following PHI to be released from the medical record of:** | | | | |
| Name of Patient | | | Date of Birth | |
| Phone Number | | Alt. Phone | | |
| Address | | | | |
| City | State | | | Zip Code |

**Release Records North Texas Spine & Pain** **Release Records**

|  |  |  |
| --- | --- | --- |
|  | |  |
| **Doctor/Facility** |
| **Address** |
| **City State Zip** |
| **Phone Fax** |
| **Purpose of Disclosure:** | | |
|  | Changing Physicians  Continuing Care Second Opinion Personal Use Insurance  School  Legal Purposes  Other | |

**From** Pain Management **From**

**To** 1001 Sara Swamy Drive Suite A **To**

Sherman tx 75090

Office: 903-892-1999 Fax: 903-892-6999

|  |  |  |
| --- | --- | --- |
| **Information to be released** | | |
| **Dates** | | From To\_ |
|  | History & Physical Exam  Follow Up Notes Operative Reports Labs Imaging/Diagnostic Tests Nutrition Notes Psychiatric Notes Other | |

**Your initials are required to release the following information:**

Mental Health Records (Excluding psychotherapy notes) Genetic Information (Including Genetic Test Results)

Drug, Alcohol, or Substance Abuse Records HIV/AIDS Test Results/Treatment Cancer Treatment Records

**EFFECTIVE TIME PERIOD**: I understand that this authorization will expire 90 days from my last date of service visit. A photocopy of this form will be considered as valid as the original. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

**RIGHT TO REVOKE:** I understand I may revoke this authorization, in writing, at any time by notifying the North Texas Spine And Pain Center/Pain Management at the address indicated below. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. However, other state or federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment, cancer treatment, HIV/AIDS related information, and psychiatric/mental health information.

**By signing below, I acknowledge that I have read and understood the authorization.**

**Signature of Patient or Legal Authorized Representative Date**

**OR**

**Signature of Parent/Legal Guardian Date**

North Texas Comprehensive Spine & Pain Center/Pain Specialist

1001 Sara Swamy Drive Suite A , Sherman Tx,75090 Office: 903-892-1999 Fax: 903-892-699