AUTHORIZATION TO RELEASE HEALTH INFORMATION

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

Patient Name: _____ Date of Birth: _____/_____/_____

I authorize the following individual or organization **to disclose** the above named individual's health information:

Optimum Pain & Regenerative Medicine (D. Michael Forman, MD ◆ Victor A. Pallares, MD)
2121 Pease Street, Ste. 305 ◆ Harlingen, Texas 78550 ◆ Phone #: 956/440-7246 ◆ Fax #: 956/440-9517

This information may be **RELEASED TO** and used by the following individual or organization:

Name/Facility: _____ Address: _____

Phone #: _____ Fax #: _____

For the purpose of: Continuity of Care /_____

Please release the following: _____ Specific Dates (_____ to _____)

Or

_____ Consultation
_____ Progress Notes
_____ History/Physical
_____ Medication List
_____ Doctor's Orders
_____ Procedure Notes from (Date) _____ to _____
_____ Imaging Reports from _____ to _____
_____ Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___ **Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

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 understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation does not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____/_____/_____. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carried with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the **Medical Records Dept**.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical record may contain reports, test results, and notes that only my physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold Optimum Pain & Regenerative Medicine liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Identification of requestor of patient information verified: YES ___ NO ___

Type: _____