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 From To

North Texas Spine & Pain
Pain Management
1001 Sara Swamy Drive Suite A
Sherman Tx 75090
Office: 903-892-1999 Fax: 903-892-6999

Release Records From To

Doctor/Facility

Address

City **State** **Zip**

Phone **Fax**

Information to be released

Dates From _____ To_____

- History & Physical Exam _____
- Follow Up Notes _____
- Operative Reports _____
- Labs_____
- Imaging/Diagnostic Tests _____
- Nutrition Notes _____
- Psychiatric Notes _____
- Other_____

Purpose of Disclosure:

- Changing Physicians
- Continuing Care Second Opinion
- Personal Use
- Insurance
- School
- Legal Purposes
- 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**