balcones
PAIN CONSULTANTS

Matthew McCarty, MD | Gus Lowry, MD | Rey Ximenes, MD

Please fax all records to 512- 834- 4142

Authorization Form For Release of Medical Records and Protected Health Information

You have the right to receive a completed copy of this form. Photocopy/Fax copy may be used as original. By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____ **DOB:** _____

CHECK ONE: ☐ Requesting Records **FROM** ☐ Sending Records **TO**

☐ Requesting Records for **SELF (fee may apply to this request for records)**

Facility Name or Physicians Name: _____

Address: _____ **City, ST, Zip:** _____

Phone Number: _____ | **Fax Number:** _____

Information to be disclosed:

- ☐ Last Four (4) Office Visit Notes
- ☐ Laboratory Tests- last 2 tests
- ☐ Radiology- Last two years
- ☐ All Records
- ☐ Other: _____
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Reports

I understand that this will include information relating to:

- ☐ Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV)
- ☐ Behavioral Health Service/Psychiatric Care
- ☐ Treatment for alcohol and/or drug abuse

This information is to be disclosed to Balcones Pain Consultants for the purpose of PAIN MANAGEMENT TREATMENT. The facility, its employees, officers, and physician are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Name of Patient or Personal Representative **Description of Rep's Authority**

_____ _____

Signature of Witness **Date**