AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. This form must be completely filled out.

Patient Name: _____ DOB: _____

Medical Provider to release records:

Persons/organizations receiving the information:

Dr. Eric Ray
Southlake Pain Center
731 E. Southlake Blvd #110
Southlake, TX 76092
817-898-7277
Fax records to: 817-527-5119

Please send:

___ Entire chart ___ Radiology reports ___ Office Notes ____ Other: _____

Section B: Must be completed only if a health plan or health care provider has requested the authorization

* Will the health plan or care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ____ yes ____ no

* I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

* I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Section C: Must be completed for all authorizations

* What is the purpose of the use or disclosure?: ___continue treatment/mutual patient_____

* I understand that this release will expire 180 days from the date signed.

* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information.

_____ _____

Signature of patient or patient's representative Date

(Form MUST be completed before signing)

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION