Please Fax Records to
512.485.7224

Medical Record Request Form

By signing this form, I authorize the release of confidential health information about me.

Patient name _____ Date of birth _____

I authorize (Please Print) _____
to release my medical records to:

PAIN SPECIALISTS OF AUSTIN
www.painspecialistsofaustin.com
4100 Duval Rd, Bldg. III, Ste. 200
Austin, TX 78759
P: 512.485.7200 F: 512.485.7224

I authorize the following information to be released:

☐ Office Visit Notes	☐ Radiology	☐ ER Reports
☐ Operative Reports	☐ EMG/NCV	☐ Physical Therapy Notes
☐ Labs	☐ Mental Health	☐ Verbal Communication/Phone Notes

☐ Other _____

Pertaining to the following dates of service _____

I understand that the information released from my medical records may contain any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS. Any restrictions to this release are specified here: _____

I understand that the releasing facility will provide this information within 15 days from receipt of request. I also understand that I have the right to revoke this authorization at any time in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. This authorization expires within one year of signed date unless otherwise specified here: _____

I understand that once this information is released there is a potential for my medical information to be re-disclosed by the recipient and no longer protected by the law. However, PSA in under federal and state obligations to continue to protect such information.

The reasons or purposes for this release of information are as follows:

☐ Legal Issues ☐ Insurance Claim ☐ Personal Use ☐ Continuing Care

☐ Other _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR PART 2). The federal rules prohibit by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Patient Signature (or parent, guardian or legal representative) Date signed

_____
Printed Patient Name