CPM Consultants in Pain Medicine

Authorization to Release Medical Records

Patient Name: _____ **Date of Birth:** _____

Address:_____ **City:**_____ **State:**___ **Zip:** _____

Phone Number: _____ **Email (optional):** _____

I hereby authorize the release of my medical records as follows:

FROM: **Consultants in Pain Medicine, PLLC**
Address: 45 NE Loop 410, Ste. 850, San Antonio, TX 78216
Phone: 210-805-9800
Fax: 210-805-8770

TO: _____

Address: _____
City/State/ZIP: _____
Phone: _____ Fax: _____ Email:_____

Purpose of Disclosure (Check one):

☐ Continuity of Care ☐ Transfer of Care to New Provider ☐ Personal Use
☐ Insurance ☐ Other: _____

Information to be Released:

☐ All medical records; **OR** (check those requested below):

☐ Progress notes ☐ Procedure/Operative reports ☐ Medication history ☐ Lab reports
☐ Imaging/Radiology ☐ Other: _____

Delivery Method:

☐ Electronic Medical Record Transfer ☐ Encrypted Email
☐ Fax ☐ Paper Copy (Mail or Pick-Up)

Authorization & Acknowledgment:

I understand that:

- This authorization is voluntary and may be revoked at any time by submitting a written request to the releasing party, except to the extent that action has already been taken based on this authorization.
- Once information is released, it may no longer be protected by HIPAA.
- I may be responsible for any applicable fees allowed under Texas law for the processing and copying of medical records, postage and other delivery expenses.
- This authorization will expire two **years** from the date signed unless otherwise specified below:

Signature of Patient: _____ **Date:** _____

- If signed by a personal representative (*e.g.,* legal guardian, medical POA), complete:
  Print Name:_____Relationship:_____
  AND attach documentation of legal authority.