COASTAL BEND PAIN MANAGEMENT

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date Of Birth: _____
Address: _____
_____
Social Security Number: _____

I request and authorize: _____Phone:_____
Fax_____ to release healthcare information of the patient named above to:

Name:_____

Address:_____ City;_____ State:_____ Zip Code:_____

Phone Number:_____ Fax Number:_____

Reason for request: _____

This request and authrization applies to:

☐ Healthcare information relating to the following treatment, conditions, or dates: _____

_____

☐ All heathcare information

☐ Other: _____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

COMPLETE ONLY IF INFORMATION IS TO BE GIVEN DIRECTLY TO PATIENT:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I willnot hold _____ liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of patient or legal representative Date

_____ _____
Relationship to patient (If legal representative) Witness

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