Receive/Release Records Authorization

Patient Authorization for Spine Team Texas, P.A. to Receive/Release Protected Health Information

Phone: 817-442-9300 • Fax: 972-772-9601
3142 Horizon Rd. #100 • Rockwall, TX 75032

Patient Name (Print) | Birth Date | Telephone Number

Patient Address | City | State | Zip

This authorization permits Spine Team Texas, P.A. to receive/release individually identifiable health information about me.

I authorize Spine Team Texas, P.A. to:

- ❑ **Receive** information
- ❑ **Release** information
  Choose an option to release:
  - ❑ Fax
  - ❑ Patient Portal
  - ❑ Hard copy via mail
  - ❑ Hard copy patient pick up

Provider Name

Provider Address

Provider City | State | Zip

Provider Telephone | Provider Fax

Information requested to be received/released:

- ❑ ALL Records INCLUDING any Psychiatric Records that may be in my chart.
- ❑ ALL Records NOT INCLUDING Psychiatric Records that may be in my chart.
- ❑ Notes of specific date of service: _____
- ❑ Other: _____

Purpose for release:

- ❑ At my request
- ❑ For my treatment
- ❑ Other: _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you or treat your any differently if you choose not to sign this authorization. You can also review your health information that we have before deciding whether to sign this authorization. Our Notice of Privacy Practices explains how to see or get a copy of your health information (your medical record).

If you sign this authorization, you can revoke it later unless we have already released the information based upon this authorization. Revocation must be submitted in writing to Spine Team Texas, P.A.'s Compliance Officer at 1545 E. Southlake Blvd. #100, Southlake, TX 76092. When your health information is released as provided in this authorization, the recipient of your information often has no legal duty to protect its confidentiality. There is the potential that the recipient may re-release the information.

Today's date
(This authorization will expire 12 months from the date listed.)

X
Signature of Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient | Print Name

Source of Authority

(You may be asked to provide documentation of this relationship to the patient)
PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION