Texas Spine & Pain MD, PLLC
1055 Clarksville St # 165, Paris, TX 75460
Ph: +1(903) 401-5145; Fax: +1(903) 401-5146
Email: info@txspmd.org; Web: www.txspmd.org

Authorization to release healthcare information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

Patient's Home Phone: _____ Patient's Work/Cell Phone: _____

Patient's Address: _____

I request and authorize Dr. _____ Phone number: _____

Address: _____ Fax number: _____

To release healthcare information of the patient named above to:

Texas Spine & Pain MD, PLLC

1055 Clarksville St , Suite 165

Paris, TX -75460

PLEASE FAX RECORDS TO (903) 401–5146

This request and authorization apply to:

- ☐ All healthcare information
- ☐ Healthcare information relating to the following treatment, condition or dates:

  _____

  _____
- ☐ Other: _____

_____ Yes _____ No I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

X_____ _____

Signature of Patient / Parent or Authorized Representative Date

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.