SOBARZO MD
PAIN MANAGEMENT

Office #281-766-0854 - Fax #281-768-4376

21820 Kingsland Blvd Ste 101A Katy, TX 77450

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Medical Records Release Form)

Patient Name: _____ DOB:_____

I hereby authorize Sobarzo MD Pain Management/Arturo Sobarzo MD, PLLC, to

RELEASE MY HEALTH INFORMATION FROM:

_____
(Person or Organization)

_____
(Street Address & POBox)

_____
(City, State, Zip)

_____ _____
(Telephone Number) (Fax Number)

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want released/disclosed. If all health information is to be released/disclosed, then check ONLY the first box.

□ Complete Medical Record-ALL □ Operative Reports □ Psychological Records □ Physician Orders

□ Last 6 months of Active Treatment □ Imaging Reports □ Lab Results □ Office Visits_____

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:

I do ____ (OR) do not _____consent to release information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol/drug abuse and/or HIV testing/results, or such disclosure shall be limited to the following specific types of information: _____

EFFECTIVE TIME PERIOD: This authorization expires within (6) months from the date signed. If you wish to have the authorization expire before (6) months, please indicate the date of expiration:_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named as the RECEIPENT of the medical records and to Sobarzo MD Pain Management/Arturo Sobarzo MD I understand that prior actions taken in reliance on the authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. It is further understood that the information is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

Signature of Patient or Legal Representative* Date