PRINCIPLE
SPINE AND PAIN

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7111 Medical Center Dr. Suite #100 Texas City, TX 77591
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Medical Record Release Authorization Form

1. I,_____ DOB:_____
   hereby authorize:

   a. Principle Spine and Pain and its associates/employees to use, obtain and/or disclose my protected health information.

   b. Providers / Facility Name:_____ Fax: _____
   to release my medical records to Principle Spine and Pain and it's associates/employees.

2. Reason for release of medical records (mark a, b, or c below).
   a. _____Continuation of Care
   b. _____Insurance change
   c. _____Other: _____

3. I hereby authorize (mark a or b below).
   a. _____The release and use of my complete health and mental record.

   OR

   b. _____I hereby authorize the release and use of my complete health record except for: (check records that you DO NOT want to send).
      i. _____Alcohol/drug abuse treatment
      ii. _____Communicable Disease
      iii. _____Mental Health Records
      iv. _____Other: _____

4. I understand that the information released may be disclosed by the recipient and may no longer be protected.
5. I am voluntarily releasing and authorizing the use of information protected by law.

_____ _____
Signature of Patient or Authorized Individual Date

_____ _____
Printed name of Patient or Authorized Individual Date