LEGACY PAIN ASSOCIATES

Mark Barhorst, MD
Clayton Barhorst, MD
9920 Cypresswood Drive
Houston, TX 77070
TEL 832.953.2280 • FAX 832.953.2829

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name ____ **DOB** ____________________________

Phone ____

Released to:

Name: Legacy Pain Associates

Phone: 832-953-2280

Fax: 832-953-2829

Released from:

Name: ___________________________________

Phone: ___________________________________

Fax: ____________________________________

_____ **Please provide a complete copy of my file for all dates of service.**

_____ **Please provide a complete copy of my file for dates of service: from** ____________ **to** ______________

Please release the following:

_____ Medical Records   _____ Progress Notes   _____ Diagnostic Reports

_____ Radiology Reports   _____ Op Reports   _____ Lab Reports

_____ Other (Specify) ____

Including information (if applicable) pertaining to: Mental Health _______ Drug/Alcohol ________ HIV/AIDS ______

Purpose or Need for Disclosure:

Continued Patient Care _______   Patient Use _______

Attorney/Legal _______   Insurance Claim/Application ________

Disability Determination _______   Other (Specify)___________________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

____   ____________________________

Signature of Patient or Legal Representative   Date