AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

WILLIAMSON
PAIN INSTITUTE

Patient Name:_____Date of Birth_____

Address:_____City/State/Zip:_____

Phone: Cell)_____

ABOVE LISTED PATIENT AUTHORIZES THE FOLLOWING HEALTHCARE FACILITY TO MAKE RECORD DISCLOSURE:

Facility Name:_____Facility Phone:_____

Facility Address:_____Facility Fax:_____

City/State/Zip:_____

THE PURPOSE OF DISCLOSURE IS: __Change of Insurance/Physician __Continuation of Care __Treatment __Referral
__Other_____

THIS REQUEST AND AUTHORIZATION APPLIES TO: (check all that apply)
__Clinical Notes __Progress Notes __History/Physical __Discharge notes __Radiology reports
__Lab Reports __Urgent care __Pathology Reports __Operative reports __Physician Orders
__Other_____

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:
Release to:

WILLIAMSON PAIN INSTITUTE
1603 Medical Parkway Bldg. 3, Suite 330
Cedar Park, TX 78613
FAX: 844-938-4727 PHONE: 512-244-4383

I understand that the authorization for disclosure of records as detailed above, unless specifically limited by me in writing, will extend to all aspects of treatment provided. These records may include testing for all sexual transmitted diseases, AIDS, and hepatitis, as well as drug, alcohol and/or psychiatric information. Williamson Pain Institute is hereby released from all legal responsibility of liability for the release of the above disclosure of information. I have the right to withdraw this authorization at any time and that such revocation must be in writing.

Patient Signature_____Date:_____

Print patient name:_____

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED