1006 Windsor Lakes Blvd STE 150 Conroe TX, 77384
PH: (281).292.PAIN(7246) Fax: (281).292.3996

Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I authorize **The Woodlands Pain Institute** to disclose the above named individual's health information

To: _____ Address: _____

City, State: _____ Zip Code: _____

Phone: _____ Fax: _____

For the purpose of: _____
Please release the following: __ Entire Record, OR

- ☐ Problem List
- ☐ History/Physical Exam
- ☐ Medication List
- ☐ List of Allergies
- ☐ X-Ray/Imaging reports
- ☐ X-Ray Films
- ☐ Other _____

I understand that the information in my health records may include information relating to sexual transmitted disease, acquired immune deficiency 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.

____ **YES,** I consent to the release of this information. ___ **NO,** I do not consent to release this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present any written revocation to The Woodlands Pain Institute. I understand that this revocation will not apply to any information already released to response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary.

_____ _____
Printed Name and Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

THE Woodlands PAIN INSTITUTE

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