ADVANCED PAIN
INSTITUTE OF TEXAS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

NAME:_____ DATE OF BIRTH_____

SOCIAL SECURITY NUMBER:_____

TO:_____
(Physician, Facility/Hospital, Attorney, Insurance Company, Self)

_____
(Address)

_____
(Phone and Fax)

FROM:_____
(Physician, Facility/Hospital, Attorney, Insurance Company, Self)

_____
(Address)

_____
(Phone and Fax)

Information to be released:

☐Office Notes ☐Imaging Reports ☐Discharge Summary
☐Procedure Notes ☐Labs ☐Other _____

Reason for disclosure:

☐Continuity of Care ☐Legal ☐Insurance
☐Social Security/Disability ☐Work/School ☐Other_____

This authorization expires 1 year from signature date.

_____
(Signature) (Date)

_____
(Witness) (Date)

500 W. Main Street, Suite 230
Lewisville, TX 75057
Ph: 972-866-4246 Fx: 972-866-4249
apitexas.com