CONSULTANTS IN PAIN MEDICINE

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ DOB:_____

Social Security#_____

I hereby authorize the release of my medical records

[please check] ☐ to / ☐ from:

Consultants in Pain Medicine, P.A.
Raul G. Martinez, M.D.
Fax: 210-441-4330

Requesting medical records [please check] ☐ to / ☐ from:

(please enter complete address)

_____

_____

_____

ATTN: MEDICAL RECORDS DEPARTMENT

PH: _____ FX: _____

Please circle all that apply:

Labs
CT Scan
MRI Report
Medications
Current X-Rays
Last 3 Progress Notes
All Medical Records

Patient Signature: _____ Date: _____

This authorization will automatically expire two (2) years from the date signed. In order to comply with regulation for Health Insurance Portability and Accountability Act (HIPAA) governing the confidentiality of patient information, a fully completed, HIPAA compliant, Authorization to Release Medical Records must accompany each request for medical records even though you may have already obtained a signed consent from the patient.

We are sorry for any inconvenience this may cause, but the laws were enacted to protect the confidentiality of medical information. Physician must comply with HIPAA privacy standards by requiring a fully completed form with all required information before releasing patient information

Thank you for your cooperation.