TEXAS PAIN INSTITUTE

Office: 817-348-8600 **Fax**: 817-348-8602

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

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

Patient Name: _____ **Date of Birth:** _____
MM/DD/YYYY

I authorize the following individual or organization to disclose the above named individual's health information:

Ved V Aggarwal MD PA, DBA, Texas Pain Institute, 1000 Lipscomb Street Suite 110 Fort Worth Texas 76104

This information may be disclosed to and used by the following:

Individual/Organization: _____

Fax Number: _____ **Phone Number:** _____

Address: _____

Please release:

- ☐ **Consult Notes**
- ☐ **Procedure Notes**
- ☐ **Lab Results**
- ☐ **Other** _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency 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 the release of this information.

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 have a right to revoke this authorization at any time.
- ✓ If I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information.
- ✓ The revocation will not apply to information already released in response to this authorization.
- ✓ 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.
- ✓ Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.
- ✓ Authorizing the disclosure of this health information is voluntary.
- ✓ I can refuse to sign this authorization.
- ✓ I need not sign this form in order to ensure treatment.
- ✓ I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.
- ✓ Any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- ✓ If I have questions about disclosure of my health information, I can contact Prospira Paincare Compliance Officer 561-279-3613.

_____ _____

Signature of Patient or Legal Representative Date