Pain & Spine Associates of Texas

Vaibhave Y. Parikh, M.D.

Medical Records Release

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED IN FULL.

Patient's Name: _____

Date of Birth: _____ Phone: _____

Address _____

_____

The information is to be released to:

Name: Pain & Spine Associates of Texas

Address: 2743 Smith Ranch Rd., Suite 404
Pearland, TX 77584

Phone: (713) 955-3755 Fax: (855) 865-3826

The information I wish to have released (included dates of service)

_____	History & Physical	_____	Reports & Operation
_____	Reports & Diagnosis	_____	Cardiac & EKG Reports
_____	Imaging Reports (CT, MRI, X-Ray)	_____	Laboratory Reports
_____	Audiograms	_____	All Records
	Do not copy anything related to:	_____	

This authorization will automatically expire one year from the date signed. I understand that I can revoke this authorization at any time. I understand that a revocation is not effective to the effective to the extent that any person or entity has already acted in reliance or my authorization of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Patient Signature or Personal Rep: _____ Date: _____

IF SIGNATURE IS OTHER THAN PATIENT, PLEASE EXPLAIN YOUR AUTHORITY TO ACT FOR THIS PATIENT

Witness Name: _____ Date: _____