CONSULTANTS IN PAIN MEDICINE, P.A.

423 Treeline Park, Suite 325
San Antonio, TX 78209

Michael L. Murphy, M.D.
Shaun C. Jackson, M.D.

PH: (210) 546-1460
FAX: (210) 447-6351

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Social Security #: _____/_____/_____

DOB: _____/_____/_____

I hereby authorize the release of records to:
Name: _____
Please enter complete address of recipient of records

_____

_____

Records requested: _____

For the purpose of: _____

_____

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**.

This Authorization to Release Medical Records will expire in six months from the date of the patient's signature.

Requests with incomplete addresses will not be processed