


TEXAS PAIN CENTERS
800 BONAVENTURE WAY, SUITE 119
SUGAR LAND, TX 77479
PHONE: 832-730-7246
FAX: 844-302-5696

Medical Records Request Form

(A) Patient Information

Name: _____

Date of birth (MM/DD/YYYY): _____

Address: _____

Phone: _____

City: _____ State: _____ ZIP: _____

(B) What information are you requesting? (Mark all that apply)

Date(s) of service: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Clinic/ Outpatient Record
(includes history and physical exam, progress notes, operative and pathology reports, consultation reports, imaging & diagnostic studies reports) | <input type="checkbox"/> consultation reports, imaging & diagnostic studies reports | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Inpatient Abstract (includes face sheet, discharge summary, history and physical exam, progress notes, operative and pathology reports, | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Lab Results |
| | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Progress Notes |
| | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Past/Present Medications |
| | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Patient Allergies |
| | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Billing (Claim) Information |
| | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____ |
| | | <input type="checkbox"/> All health information |

Mental/behavioral health records (may require physician/psychologist approval):

Psychiatric/mental health records Neuropsychological testing Addiction treatment records Other _____

(C) Purpose of Disclosure:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Treatment/Continuing Medical Care | <input type="checkbox"/> Insurance | <input type="checkbox"/> School |
| <input type="checkbox"/> Billing or Claims | <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Employment |
| | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other _____ |

(D) Please send patients health information to:

Texas Pain Centers, 800 Bonaventure Way Suite 119, Sugar Land, TX 77479, USA

Phone 832-730-7246

Fax: 844-302-5696

E-mail: staff@texaspaincenters.org

(E) Terms of Authorization: I understand this authorization may be revoked in writing at any time, according to the instructions in Texas Pain Centers Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization. **The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental, addiction or behavioral health or psychiatric care as well as psychotherapy notes.**

Signature _____ Date: _____

Printed name: _____ Relationship to patient: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certaintypes of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Minor's Signature: _____ Date: _____