TEXAS PAIN CENTERS
3519 TOWN CENTER BLVD, SUITE B
SUGAR LAND, TX 77479
PHONE: 832-730-PAIN (7246)
FAX: 844-302-5696

Medical Records Request Form

This form is used to request copies of medical records. Only patients or their legal representatives may make a medical record request. Some requests (e.g. personal copy / use) may be subject to a reasonable fee.

(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:_____

☐ Clinic/ Outpatient Record (includes history and physical exam, progress notes, operative and pathology reports, consultation reports, imaging & diagnostic studies reports)
☐ History/Physical Exam
☐ Operative Reports
☐ Pathology Reports
☐ Consultation Reports
☐ Radiology Reports & Images
☐ EKG/Cardiology Reports
☐ Lab Results
☐ Progress Notes
☐ Past/Present Medications
☐ Patient Allergies
☐ Billing (Claim) Information
☐ Other_____
☐ **All health information**

Mental/behavioral health records (may require physician/psychologist approval):
☐ Psychiatric/mental health records ☐ Neuropsychological testing ☐ Other _____

(C) Purpose of Disclosure: (Please select only one box)

☐ Personal Use
☐ Treatment/Continuing Medical Care
☐ Billing or Claims
☐ Insurance
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment
☐ Other _____

(D) To be completed only for third-party disclosures. (If the disclosure is for personal use, skip this section.)

I want the requested medical records to be sent to the third-party (e.g. health care provider etc.) I have indicated below. My completion of this form serves as authorization for Texas Pain Centers to disclose these records to this person or group. I understand that once my information leaves Texas Pain Centers, Texas Pain Centers is no longer able to protect the information, and the recipients of my information may not be legally required to protect my information.

Name:_____Phone_____

Mailing Address:_____

(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. Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated here:_____ . If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. **The information released may contain information related to AIDS or HIV infection; drug or alcohol abuse; mental or behavioral health or psychiatric care, except for 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:_____

Mail or deliver completed form to:
Texas Pain Centers
3519 Town Center Blvd, Suite # B, Sugar Land, TX 77479
Fax: 844-302-5696 / E-mail: staff@texaspaincenters.org