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

(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)

☐ Inpatient Abstract (includes face sheet, discharge summary, history and physical exam, progress notes, operative and pathology reports, consultation reports, imaging & diagnostic studies reports)

☐Discharge Summary

☐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 ☐Addiction treatment records ☐Other ____________________

(C) Purpose of Disclosure:

☐Treatment/Continuing Medical Care

☐Billing or Claims

☐Insurance

☐Legal Purposes

☐Disability Determination

☐School

☐Employment

☐ Other_____________________

(D) Please send patients health information to:

Texas Pain Centers, 3519 Town Center Blvd, Suite # B, 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:__________