

North Texas Precision Pain Care

Treating the patient, not just the disease

Authorization to Release/Receive protected health information

Patient: _____

City: _____ State: _____ Zip code _____

Social Security#: _____ Date of birth: _____

You may release the following:

Entire Medical Records _____ Labs _____ Images: _____

Specifically: _____

Reason: Changing Practice _____ Update Medical Records _____

Please release my information to the above person by: Mail Fax Email

_____ Send To:

North Texas Precision Pain Care, PA

3550 Parkwood Blvd Suite 306

Frisco, Texas 75034

Fax: 214-618-2102

_____ Send to:

This authorization is effective as of today's date _____ and has no expiration date unless revoked or terminated by the patients personal

Signature: _____ Date: _____