Consultants in Pain Medicine, P.A.

*5368 Fredericksburg Rd Ste 210
San Antonio TX, 78229

*116 Gallery Circle St.202
San Antonio TX, 78258

*10423 Hwy 151 Ste.103
San Antonio TX, 78251

PH: 210-546-1470 FAX: 210-546-1479

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ SS #_____/_____/_____
(Please print name legibly)

DOB: ____/____/_____

I hereby authorize the release of Medical records to:

Dr. Mark Moran
5368 Fredericksburg Rd Ste 210
San Antonio TX 78229
(210) 546-1470

Records requested: _____

For the purpose of: _____

PLEASE SIGN AND READ

There records are being provided to you free of charge this time along with any updates requested. However due to the increased cost of doing business, any subsequent requests for another complete set of records will results in a charge.
Charges are as follows: Medical Records--$25.00 for the first 20 pages and .50 each page thereafter. Billing Records-- $25.00 flat fee

Patient Signature: _____ Date: ____/_____/_____

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*In order to comply with regulations for Health Insurance Portability and Accountability act (HIPPA) governing the confidentiality of patient information, a fully completed, HIPPA 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 are enacted to protect the confidentiality of medical information. Physicians must comply with HIPPA 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***