Kendall Carll, MD
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Mailing/Business Office
8080 Independence Pkwy, Suite 230
Plano, TX 75025
PH: 469.998.2273 (CARE)
Fax: 469.998.2272

Authorization to Release Information

Upon presentation of this authorization you are requested to provide the records outlined below to:

To Recipient: ____
Person/Company

____
Address City State Zip

____
Phone Fax

From Clinic/Hospital:

____

Patient:

____
Patient Name Date of Birth Phone

Dates of Service (Check one and complete dates of service if required)

- ☐ Please provide a complete copy of my file for all dates of service.
- ☐ Please provide a complete copy of my file for service from: ____________________ through ____________________

Records to Be Released

☐ All Medical Records ☐ Progress Notes ☐ Labs ☐ Op Reports ☐ Radiology Reports
☐ Correspondence ☐ Hospital Records ☐ Test Results ☐ Other Provider Records
☐ Consultations ☐ PT Notes ☐ Billing Records

Purpose for Disclosure

☐ Continuity of Care ☐ Disability ☐ Insurance ☐ Attorney ☐ Patient Request
☐ Other: ____

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization.

☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS.

This authorization will expire one hundred and eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

______________________________ ____
Date Signature

____
Printed Name of Patient or Legally Authorized Representative

PLEASE RETURN COMPLETED FORM TO FAX # 469.998.2272
OR EMAIL: RECORDS@SPINECAREOFNORTHTEXAS.COM