Clear Lake Brain and Spine Institute

1045 Gemini Street, Suite 200-A Houston, Texas 77058
Ph: 832-224-4204
Fax: 281-280-0065

Authorization to Release/Obtain Medical Records (Please Print)

Patient Name: _____

Date Of Birth: _____

Phone Number: _____

I, undersigned, consent to the release of medical information (records)

TO / FROM: TO / FROM (please include phone & fax)

Clear Lake Brain and Spine Institute _____

1045 Gemini St. Ste. 200A _____

Houston, TX 77058 _____

Records to be released: (choose one)

All Records or Other:_____

Purpose of disclosure:_____

This authorization is given freely with the understanding that:
1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing.
4. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
5. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Patient Name: _____

Patient Signature: _____

Date: _____