SPINE AND PAIN CLINIC
Tel. (281) 741-3243 Fax (281) 741-8763
Johnson Ukpede, M.D.

Medical Record Release Authorization Form

1. I, _____ DOB: _____ hereby authorize:

   - ☐ Printed Patient Name Patient DOB
   - ☐ Delta Spine and Pain Clinic and its associates/employees to use, obtain and/or disclose the protected health information.
   - ☐ _____ to release my medical record to

     Delta Spine and Pain Clinic and its associates/employees.

2. ☐ I hereby authorize the release and use of my complete health record.

   OR

   ☐ I hereby authorize the release of and use of my complete health record with the exception of: (check records that you do not want to send)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Communicable Diseases
   - ☐ Mental Health Records
   - ☐ Other:

_____

3. I understand that the information released may be disclosed by the recipient and may no longer be protected.

4. I am voluntarily releasing and authorizing the use of information protected by law.

_____ _____

Signature of Patient or Authorized Individual Date

_____ _____

Printed Name of Patient or Authorized Individual Relationship to Patient

_____ _____

Witness' Signature Date