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**Authorization Form For Release of Medical Records and Protected Health Information**

You have the right to receive a completed copy of this form. Photocopy/Fax copy may be used as original. By signing this form, I authorize you to use and disclose the protected health information described below.

**Note to client:** A fee may apply to this request for records.

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**CHECK ONE:** Requesting Records FROM  Sending Records TO  Requesting Records for SELF

**Facility Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Information to be disclosed:**

- Last Four(4) Office Visit Notes
- Laboratory Tests-LAST TWO (2) LAB TESTS
- Radiology- LAST TWO (2) YEARS
- Discharge Summary-IF APPLICABLE
- History & Physical-IF APPLICABLE

**I understand that this will include information relating to (Check if applicable):**

- Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV)
- Behavioral Health Service/Psychiatric Care
- Treatment for alcohol and/or drug abuse

This information is to be disclosed to Balcones Pain Consultants for the purpose of **PAIN MANAGEMENT TREATMENT.**

The facility, its employees, officers, and physician are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Patient or Personal Representative**

\_\_\_\_\_  
**Description of Rep's Authority**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

**Fax to One Location Listed Below**

5200 Davis Lane Ste  
B-200 Austin, TX 78749  
512-834-4142

1706 W. Hwy 1431  
Marble Falls, TX 78654  
830-201-4092

181 Cimarron Park Loop, # A  
Buda, TX 78610  
512-834-4142

1009 W. San Antonio Street  
Lockhart, TX 78644  
512-834-4142

500 West Whitestone, # 250  
Cedar Park, TX 78613  
512-834-4142