ConquestMD®
Spine Care and Sports Medicine, PLLC

6850 TPC Drive, Suite 116, McKinney, TX 75070 phone: (214) 544-9887 Fax: (214) 544-9888 www.conquestmd.com

Authorization of Release of Patient Information

Name of Patient: ____ Phone Number: _____________________

Other Names Used: _______________ Date of Birth: ______________Social Security Number: XXX-___-_____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

Patient information is needed for: Continuing medical care

☐ All date(s) of service ☐ Specific date(s) of service: __________________________

Information to be released:

☐ History & Physical
☐ Consultation Report
☐ Radiology Reports
☐ Radiology Images
☐ Emergency Room Record
☐ Operative Reports
☐ Lab/Pathology Reports
☐ Discharge/Death Summary
☐ Face Sheet
☐ Discharge Instructions
☐ Other: ____________________

Format Requested For Information to be Provided:

☐ Paper
☐ Electronic Media (Requires 2 Business days; only applies to data stored electronically)

Method of Delivery:

☐ Patient will pick up
☐ Fax to: **ConquestMD Spine Care and Sports Medicine @ (214) 544-9888**
☐ Mail to address listed below:

____ may release my information to:
(hospital or facility name)

Ainsworth B. Farrell, M.D.
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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 recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history , diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

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 I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records accord Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: ____________________________________

Signature: ____ **Date:**________________________
Patient or legally authorized representative

____ ______________________
Printed name of patient or legally authorized representative Relationship to patient