Methodist
BRAIN AND SPINE INSTITUTE

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: ____ Birth Date: _________________
Previous names: _________________________________Social Security#: __________________
Mailing Address: _________________________City:__________ State: ______ Zip: _________
Phone number: _______________________________ Physician Seen: ____________________

Please circle below:
I (do) (do not) authorize the use or disclosure of my medical records and patient health information, as described below. If you wish to release records please complete the remaining portion of the form. Please allow 3-5 working days to process request.

1. I authorize Methodist Brain and Spine Institute to release my records from their organization.

2. Please release my records to the following individual or organization listed below:
   Person, clinic, organization name: ____
   Address: ____________________________ City: _________ State: ______ Zip: __________
   Phone: _____________________________ Fax: ___________________________________

3. The Type of information to be released is as follows: (Please Check)

___ Entire Health Record	___ Operative Procedures	___ Pathology Report
___ History & Physical	___ X-ray/Imaging Reports	___ Echocardiogram
___ Laboratory Reports	___ Billing Records	___ Office Notes

4. Purpose: ☐ Continued Care By Another Provider ☐ Insurance Claim ☐ Personal Use
☐ Social Security Disability ☐ Attorney Review ☐ Other

5. I understand the following:
   - My patient health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.
   - Once the records are released to the person, clinic or organization named above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party.
   - To be valid, this form must be filled out completely and signed. This authorization will expire one year from the date of signing. Unless otherwise specified. _______________
     Expiration Date

____________ ____

Date/Time Signature of patient or authorized person (proof required)

Methodist Moody Brain and Spine Institute

www.methodistbrainandspine.com

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PROVIDERS
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LOCATIONS
Addison
17101 North Dallas Parkway
Addison, TX 75001

Dallas (Downtown)
1411 N. Beckley Ave
Pavilion III, Suite 152
Dallas, TX 75203

Southwest Dallas / Duncanville
3430 Wheatland Rd
Professional Building I, Suite 216
Dallas, TX 75237

Richardson
2821 E. President George Bush Hwy, Suite 410
Richardson, TX 75082

Mansfield
2800 E. Broad Street
Professional Building, Suite 514
Mansfield, TX 76063

Sunnyvale / Mesquite
341 Wheatfield Dr, Suite 100
Sunnyvale, TX 75182

CONDITIONS / DISORDERS
Acoustic Neuroma
Aneurysm
Arteriovenous Malformation (AVM)
Back & Leg Pain
Brain Tumors
Brain Injury
Carpal Tunnel Syndrome
Cerebrovascular Disorders
Neck & Arm Pain
Nerve Disorders
Pituitary Tumors
Scoliosis
Spinal Cord Injury/Fractures
Spinal Disorders
Spinal Tumors
Radiosurgery
Trauma
Trigeminal Neuralgia