SPINE & JOINT
PAIN SPECIALISTS

The Practice of Wm. Alec Tisdall, MD

Authorization to Release Medical Records

Name of Patient _____ Date_____
Date of Birth _____ SS# _____

○ I hereby request and authorize the release of all medical records concerning treatment including:

- Last three office notes
- Initial evaluation
- Medication logs
- X-Ray Reports, MRI's, and/or CT Scans
- Other: _____

From:_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)
Phone Number:_____**Fax:**_____

To: William Alec Tisdall, MD PA dba Spine & Joint Pain Specialists

Ph: 210-541-0700 Fax: 210-541-6868 Attn:_____

○ I hereby request and authorize the release of copies of all medical records

From: William Alec Tisdall, MD PA dba Spine & Joint Pain Specialists

To: _____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)
Phone Number:_____Fax:_____
Address:_____

This authorization will expire 1 (one) year from the date of my signature, unless I revoke the authorization prior to that time.

_____ _____
(Signature) (print Name)

Patient or Legally Authorized Representative:

_____ _____
(Signature) (print Name)
Relationship to Patient: _____

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 by the 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 HIV and AIDS. 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.