FRIUS FUNCTIONAL RESTORATION INSTITUTE U.S.

MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. This form must be completely filled out.

PATIENT INFORMATION:

Name: _____ SSN#: _____ DOB: _____

Phone #: _____ Email: _____

MEDICAL PROVIDER TO RELEASE RECORDS:

_____

_____

_____

_____

PERSONS/ORGANIZATION TO RECEIVE RECORDS:

_____

_____

_____

_____

What is the purpose of the use or disclosure?: _____

I understand this authorization may be revoked in writing at any time by notifying the providing organization, but if I do it won't have any effect on any actions they took before they received the revocation.

Unless otherwise revoked, this authorization will expire on the sooner of 180 days from the date of this authorization or on the date indicated here: _____.

I understand that my records are protected under State and Federal law. The information released may contain information related to AIDS or HIV infections; drug or alcohol abuse; mental or behavioral health care, or any other medical information. FRA and/or PRIDE will not condition treatment or payment on my completion of this form.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Medical Records Management Company:

Lexa Records
99 Trophy Club Drive
Trophy Club, TX 76262
P: 817-421-4700 F: 817-421-4766
Email: info@lexarecords.com