



Authorization to Obtain Records

ON REQUEST — RECORDS FROM A PRIOR PROVIDER

PATIENT DOB MRN DATE

This form authorizes another provider or facility to send your records to Abilene Pain. Our staff will fax it on your behalf.

Send My Records From

Provider / facility

Phone / fax Fax City

Records Requested

☐ All records from the last 2 years ☐ Visit notes ☐ Imaging reports and images ☐ Procedure notes

☐ Medication list / controlled-substance agreement ☐ Lab and drug-screen results ☐ Other:

Purpose: ☐ Continuation of care ☐ Transfer of care / change of physician Include if checked: ☐ Mental health

☐ Drug or alcohol treatment ☐ HIV / AIDS

Send To

Abilene Pain Phone 325-326-3433 Fax 325-378-9175

Patient address Phone

My Rights

- I may revoke this authorization at any time by written notice to Abilene Pain, except to the extent action has already been taken in reliance on it.
- Abilene Pain will not condition my treatment or payment on whether I sign this authorization. Information received may be re-disclosed by Abilene Pain only as permitted by law and its Notice of Privacy Practices.
- Unless I write an earlier date here, this authorization expires one year from the date signed: . A copy is as valid as the original.

Signature

I have read this authorization and understand it. I authorize the provider or facility named above to release the records described to Abilene Pain.

PATIENT SIGNATURE

DATE

PRINTED NAME AND RELATIONSHIP, IF SIGNED BY A REPRESENTATIVE

Nicolas Pugh, MD | Adrianne Anders, NP | Ted Chaka, PA

Abilene Pain Locations

Main: 1925 Hospital Place, Abilene, TX 79606

Additional: 6819 Memorial Dr, Ste B, Abilene, TX 79606

Contact Numbers

Main: 325-326-3433

Memorial: 325-468-8096

Online

Email: info@abilenepain.com

Web: www.abilenepain.com