Tel. (281) 741-3243 Fax (281) 741-8763
Johnson Ukpede, M.D.

Medical Record Release Authorization Form

1. I, ____________________________ DOB: __________________ hereby authorize:

- ☐ Printed Patient Name   Patient DOB
- ☐ Delta Spine and Pain Clinic and its associates/employees to use, obtain and/or disclose the protected health information.
- ☐ ____________________________________ to release my medical record to

  Delta Spine and Pain Clinic and its associates/employees.

2. ☐ I hereby authorize the release and use of my complete health record.

   OR

   ☐ I hereby authorize the release of and use of my complete health record with the exception of: (check records that you do not want to send)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Communicable Diseases
   - ☐ Mental Health Records
   - ☐ Other:

____

3. I understand that the information released may be disclosed by the recipient and may no longer be protected.

4. I am voluntarily releasing and authorizing the use of information protected by law.

____ ________________________________

Signature of Patient or Authorized Individual Date

____ ________________________________

Printed Name of Patient or Authorized Individual Relationship to Patient

____ ________________________________

Witness' Signature Date