Pain Specialty Consultants, P.A.
Prafulla Singh, M.D.
Phone: (210) 527 1166 **Fax (210) 527 1163**
*Diplomate American Board of Pain Medicine ~ * Fellowship in Pain Management ~ *Diplomate American Board of Anesthesiology
*Subspecialty Certification in Pain Management by American Board of Anesthesiology

Patient Release of Medical Records

Patient's Name_____**Date of Birth:**_____

S.S.# _____

I request and authorize _____

Address/Phone/Fax_____
_____
_____

To release my medical records to: **Pain Specialty Consultants, P.A.**
Prafulla Singh, M.D.
1200 Brooklyn Ave, # 140
San Antonio, TX 78212

Please mail records/ Please fax records

Information to be released :

_____**Copy of complete health records**

_____**Other**_____

I understand that my express consent is required to release any health care information relating to testing diagnosis, and / or treatment for HIV, sexually transmitted disease, psychiatric disorders/ mental health, or drug and / or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of Patient/ Authorized Representative_____**Relationship**_____

Date_____