



TEXAS SPINE CONSULTANTS, L.L.P.
17051 DALLAS PARKWAY
SUITE 400
ADDISON, TEXAS 75001
PHONE: 214.370.3535
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DISCLOSURE AUTHORIZATION FORM

PATIENT NAME: <u>Robert Plock</u>		
DATE OF BIRTH: <u>07/26/1968</u>	SSN: <u>456533292</u>	
ADDRESS: <u>6827 Latta Hwy</u>		
CITY: <u>Dallas</u>	STATE: <u>TX</u>	ZIP: <u>75227</u>
REQUESTED BY:		RELATIONSHIP:
PHONE: <u>214 799 7775</u>	PHONE 2: <u>214 799 1296</u>	

I authorize Texas Spine Consultants, L.L.P. ("Practice") to disclose my protected health information to those listed below (specify name, relationship and contact information if applicable):

Robert Plock - Self
Clarence Abner - Friend

- The protected health information to be disclosed is:
- ☒ Entire medical record
 - ☐ Only information relating to: _____
 - ☐ Only information occurring from: _____ to _____
 - ☐ Other (specify): "At my Request"

The protected health information is being disclosed for the following purpose (write "at my request" if there is no specific purpose or you do not wish to specify the purpose):

This authorization will be in full force and effect for two years unless otherwise indicated below.

- ☐ Expiration Date: _____
- ☐ Occurrence of the following expiration event: _____
- ☐ Upon conclusion of the research study