Coastal Bend Pain Management

Michael Tschickardt, M.D., Medical Director
Board Certified in Pain Medicine
by the American Board of Anesthesiology
Fellowship Trained in Pain Medicine

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Madeline Benavidez, FNP-C | KeiKei Robinson, FNP-BC

Medical Records Requested by: Michael Tschickardt MD

Patient Name: **Date of Birth:**
Rendering Provider: **Michael E Tschickardt, MD** **Date of Request:**

I request and authorize: _____
Phone Number: _____ Fax Number: _____
to release healthcare information of the patient named above to:

Name: **Coastal Bend Pain Management**
Address: **7101 Williams Drive** City: **Corpus Christi** State: **TX** Zip Code: **78412**
Phone Number: **361-854-1910** Fax Number: **361-884-1555**

Reason for request: _____

This request and authorization applies to:

☐ All healthcare
☐ Healthcare information relating to the following treatment, conditions, or dates: _____
_____

☐ Billing information

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Other: _____

Patient Signature: _____ Date Signed: _____

COMPLETE THE SECTION BELOW ONLY IF INFORMATION IS TO BE GIVEN DIRECTLY TO PATIENT:
I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical records to prevent my misunderstanding of the information contained in these entries. I will not hold **Coastal Bend Pain Management** liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of patient or legal representative Date

_____ _____
Relationship to patient (If legal representative) Witness