THE PAIN CENTER

COMPREHENSIVE PAIN CARE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_______________________________________ DOB:_____________________SSN:_____________________

Patient's Address:____

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Patient's Telephone: Home: ____________________ Cell: _____________________ Work:_____________________

By signing this authorization, I authorize The Pain Center to use and/or disclose medical information concerning my medical treatment including any reference or record relating to my mental health and/or substance abuse to or for the individual and/or party listed below:

Name:____ Phone :___________________________

Business Name:____ Fax :_____________________________

Address:____

____

Information to be released: (Check all that apply)

☐ Complete Medical Record
☐ Records of care from the following dates: __________________ to ___________________
☐ Records concerning the following conditions: _____________________________________
☐ Other, please specify: ____
☐ Confer with person(s) listed orally about my medical information: ___________________________________

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I understand that the medical records I authorized to be disclosed are privileged and confidential and may be disclosed only on my authorization, except as required by HIPAA and related laws or other disclosures identified in the privacy policies of The Pain Center. The authorization will expire 6 months from the date signed unless the undersigned specifies an expiration date or event or condition.

Signature of Patient or Legal Guardian: ____
Print Patient Name: ____
Print Name of Legal Guardian: (if applicable)____
Relationship to Patient: ____
Date: _________________________

PLEASE FAX TO (304)263-6536. PLEASE MAIL ANY MEDICAL RECORDS OVER 20 PAGES. THANK YOU.