PAINMD

PAIN & WELLNESS CLINICS

MEDICAL RECORDS REQUEST
AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

(All sections must be completed)

I hereby authorize _____ and its physicians, employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

I hereby authorize the release of medical records to:

_____

_____

_____

Purpose of disclosure: _____

The authorization will expire on: _____

Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Patient Name: _____ DOB: _____

_____ _____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient

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