DOCTORS© PAIN CLINIC

Authorization for Release of Information

PATIENT INFORMATION:

First Name _____Middle Initial_____ Last _____

Social Security Number: _____ Date of Birth: _____/_____/_____

I, THE UNDERSIGNED, HEREBY AUTHORIZE:

Facility Name:_____ Phone: _____

Address: _____

TO PROVIDE:

Facility Name:_____ Phone: _____

Address: _____

WITH THE FOLLOWING INFORMATION: *(Please check box next to report(s) needed)*

☐	MRI, CT, X-RAY	☐	EMG Report	☐	Operative Report
☐	Consultation	☐	Emergency Room Report	☐	Pulmonary Functions
☐	Drug/Medication Record	☐	History & Physical	☐	Progress Notes
☐	Lab Reports	☐	Urine Drug Screen	☐	Entire Record
☐	Other:				

From the following dates of Service/treatment: _____to_____

INFORMED CONSENT: This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information. I, the undersigned, understand that my medical record may contain information related to:

- Acquired Immunodeficiency Syndrome (AIDS) or Infection with HIV
- Psychiatric Care
- Treatment for alcohol and or drug abuse

I give my consent for release of this information:

_____

Signature of Patient Date

_____

Signature if other than Patient (Relationship to patient) Date

For signature other than patient, please attach P.O.A./Legal Guardianship documentation

_____

Signature of witness Date

OFFICE USE ONLY: ☐ Patient given copy of Consent Form **Records Sent Date:** ____/____/____ by: _____(initials)

Rev. 4/2009