Pain Specialists of America

Medical Records Release

The following is an authorization for the release of medical information (including, if any psychiatric or psychological information, infectious or contagious disease information, including HIV/AIDS confidential information), and/or information about drug or alcohol abuse treatment from the health records of:

Patient name:_____ DOB:_____

Address:_____

Home Phone:_____ Cell Number: _____Work Phone:_____

To be released TO/FROM: (circle one)

Physician/Practice:_____

Address:_____

Phone:_____Fax:_____

I authorize the following information to be released:

_____Office visit notes	_____Radiology	_____ER Records
_____Operative Reports	_____EMG/NCV	_____Physical Therapy
_____Labs	_____Mental Health	_____Phone Notes

To be released TO/FROM: (circle one)

_____

_____

Phone:_____ Fax:_____

The reason or purposes for this release of information are as follows:

_____Legal Issues	_____Insurance Claim	_____Personal Use
_____Continuing Care	_____Other_____	

_____

Patient Signature Date

This release is valid for one year from the date of signature.
Please allow a minimum of 3 business days for completion of request.