PAIN DOCTOR
WE CHANGE LIVES HERE

Authorization for Disclosure and Release of Medical Records

This form is used to request the release of Medical Records.

Patient Name: _____Phone Number: _____

Address: _____
Street City State Zip Code

Date of birth: _____Date of request: _____

Please check and complete all that apply:

- ☐ Medical Records for Date(s) of: _____
- ☐ MRI Imaging and Area for Date(s) of: _____
- ☐ Other, please be specific: _____

Method of receiving medical records:

- ☐ *Pick up at clinic location. Provide location name: _____.*
- ☐ *Mail to address listed above*
- ☐ *Fax number: _____*
- ☐ **Email: _____*
- ☐ *Physician or Name of Authorized Person(s):*
  _____
  Address: _____
  Contact Phone Number: _____
  Fax Number: _____

**By requesting your medical records to be sent through unencrypted email, you understand the potential and unforeseeable risk. Initial____.*

I understand that this information shall be in effect for 180 days following the date of signature. Further, I may be revoke this authorization at any time by giving oral or written notice to Pain Doctor, Inc. A photocopy of this authorization shall constitute a valid authorization. I realize once my medical records have been released, Pain Doctor cannot retrieve them and has no control over the use of the already released copies. I understand that the health information I am authorizing may disclose additional information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

There may be fees associated in providing copies of medical records. Initial_____.

Please Note:

The attached medical information pertaining to _____ is confidential and legally privileged. Pain Doctor, Inc. has provided it to _____ as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law. I hereby release Pain Doctor, Inc. from any and all liability which may arise as a result of my authorized release of records. I understand that Pain Doctor, Inc., may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I have read this authorization and acknowledge the terms and conditions.

Print Patient Name: _____Date: _____

Signature: _____

Relationship to Patient: _____

(*Attach copy of documentation authorized as patient legal representative.)

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law. You are prohibited from making further disclosures of such information without specific consent of the patient to whom such information pertains or as otherwise permitted by state law. A general authorization is not sufficient for this purpose.