Pain Care
Specialists

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This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize ____

to release a copy of the medical information for ______________________________ *(Name of patient)*

to ____ *(Name of recipient)*

Address ____

The information will be used on my behalf for the following purpose (s): ______________________________

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By initaling the spaces below, I specifically authorize the release of the following records, if such records exist:

_____ All hospital records (including nursing records and progress notes)
_____ Transcribed hospital reports
_____ Medical records needed for continuity of care
_____ Most recent five year history
_____ Laboratory reports
_____ Pathology reports
_____ Diagnostic imaging reports
_____ Clinician office chart notes
_____ Dental records
_____ Physical Therapy records
_____ Emergency and urgency care records
_____ Billing statements
_____ Other ______________________________

Please send the entire medical record (all information) to the above named recipient. The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

_____ *HIV/AIDS-related records
_____ *Genetic testing information
_____ * Mental health information

**Must be initiated to be included in other documents*

_____ **Drug/alcohol diagnosis, treatment or referral information ______________________________

***Federal Regulation 42 CFR Part 2, requires a description of how much and what kind of information is to be disclosed.*

_____ This authorization is limited to the following treatment: ______________________________

_____ This authorization is limited to the following time period: ______________________________

_____ This authorization is limited to a workers' compensation claim for injuries of ____________________ *(Date)*

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization, unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____/_____/_____ *(Date)*

______________________________ *(Signature of patient)*

_____/_____/_____ *(Date)*

______________________________ *(Signature of person authorized by law)*