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ATTN: MEDICAL RECORDS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ DOB: _____

I hereby authorize the release of my medical records
[please check] ___To/___From
Advanced Pain Management and Rehab

Requesting medical records [please check] ____To/ ___From:
(please enter complete address, phone and fax)
_____
_____
_____

Please check all that apply:

[ ]Labs	[ ]Medications	[ ]Last 3 Progress Notes
[ ]CT Scan	[ ]Current XRays	[ ]All Medical Records
[ ]MRI Report		

I understand the following:

- This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or two years from the date signed.
- I understand I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. The information released in response to this authorization may be re-disclosed to other parties. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Patient Signature: _____ Date: _____