Pain Care Specialists
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This authorization must be completed, 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/DOB)
to _____ (Name of Recipient)
Mailing Address _____ or Fax Number _____

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

_____

By initialing 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

*Must be specifically selected 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 time period: _____
- ☐ This authorization is limited to a worker's compensation claim for injuries of: _____

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)