AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PAIN AND SPINE INSTITUTE
3400 McClure Bridge Road, Building A, Suite B, Duluth, GA 30096
Phone: 770-545-8421 - Fax: 770-545-8422
painspineinstituteatl@gmail.com

RELEASOR: PLEASE FAX THE MOST RECENT 2 YEARS OF MEDICAL NOTES AND ANY IMAGING REPORTS TO PAIN AND SPINE INSTITUTE AT **(770) 545-8422.**

Patient Name ____ Date of Birth ________________

I hereby authorize **Pain and Spine Institute** to obtain any relevant medical records for the purpose of continuity of care and treatment from:

Practice Name____

Address ____

Phone # _____________________________________ Fax # _____________________________________

Please send:

_____ All Records (Office notes, imaging results, medication history, laboratory results, etc)

_____ Specific Items ____

I understand authorization may include information related to mental health services, alcohol or drug abuse, and sexually transmitted disease results. Check each box below that applies if such information is NOT TO BE released.

____ My diagnosis or treatment for alcoholism or drug abuse or dependency **may not be released** to the recipient noted above.

____ My diagnosis or treatment concerning mental health/rehabilitation **may not be released** to the recipient noted above.

____ HIV test results and/or AIDS diagnosis and treatment **may not be released** to the recipient noted above.

This authorization will expire in one year except when revoked by the patient, legal guardian, power of attorney, or healthcare surrogate. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing.

____ ______________________________

Signature of Patient Date