APC AMERICAN PAIN CONSORTIUM

Center For Pain | Integrated Pain Solutions | Spine Care Specialists

Together With American Pain Consortium

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Expiration: _____

If you currently have an active release of information authorizing the release of your records to any person or organization, you will need to complete the form below to continue that authorization. If you do not have any current release of information authorizations, you may disregard this page.

Patient name: _____ Date of Birth: _____

Address:_____

_____

I authorize the release of: ***(Please check all that apply)***

☐ All medical records ☐ Imaging report(s) only for date(s) of service: _____

☐ Operative report(s) only for date(s) of service: _____

Please provide the above requested information to:_____
(Provider/Facility/Individual to receive records)

Fax # : _____

For the purpose of:

_____

Please initial each line below:

_____ I hereby authorize the release of the above requested medical information to the above listed recipient and understand if all medical records have been requested that all records will be released.

_____ I understand I may revoke this consent prior to any action being taken.

_____ I understand that I may be charged a fee for this service.

_____ I understand that I may revoke this authorization at any time except to the extent that information has already been released in response to this authorization. I understand that I may revoke this authorization by making the request in writing and giving it to an office staff member.

_____ I understand that information disclosed in response to this authorization may be redisclosed by the recipient and therefore is no longer protected.

_____ I understand that my treatment may not be conditioned on the signing of this authorization.

_____ _____

Patient signature/Legal representative Date