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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________________

Previous Name: ______________________________ Social Security # ___________________

I request and authorize _________________________________ to release health care information on the patient named above to:

Name: ____

Address: ____

Phone: ___________________________________ Fax: ___________________________

This request and authorization applies to:

☐ All health care information

☐ Other: ____

I understand that my express written consent is required to release any health care information relating to testing, diagnosis and/or treatment of many disorders including HIV (AIDS virus), sexually transmitted diseases, psychiatric discords/mental health, or drug and/or alcohol use. I give specific authorization to release all records to the above named individual or facility by mail or facsimile transmission. **This authorization expires 90 days after the signed date.**

Patient Signature: _______________________________________ Date: ________________

NOTE: Pain Consultants, PLLC requires notification of copy charges prior to copying.