Authorization for Release of Medical Information

Patient Name:

Patient #:

Social Security #
(last 4 digits):

Date of Birth:

Please forward copies of requested records to:

Name:
Address:
City, State, & Zip:

Release the following:
_____Entire Health Record
_____Specific Dates of Treatment: From____________to____________

Please provide the following information if your medical records are to be released to an entity other than yourself.

Name:____

Address:____

☐ This request is being made because I am transferring care to another primary care provider or leaving the area.

☐ This authorization shall remain in effect until ________________ (up to 6 months) at which time this authorization expires.

☐ I also authorize for the release of information regarding assessment, diagnosis, and treatment of alcohol and / or substance abuse.

☐ I also authorize for the release of information regarding diagnosis and or treatment of AIDS or HIV.

☐ None of the above

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Pain Management Associates, PC, attention Medical Release Correspondent, at the above address.

I hereby authorize Pain Management Associates, PC to disclose my medical information as requested. Information used or disclosed by this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by this rule.

Patient Name:

Phone: _

Patient Signature: ______________________________

Date:

Legal Representative: ______________________________
Relationship:

Date:

Witnessed by: ______________________________

Date:

THERE IS A SERVICE CHARGE OF $25.00 FOR THE COPYING OF RECORDS

You can make your payment by check, money order or credit card.

****Please note failure to include payment or complete either category will prevent or delay the release of your records.****

Credit Card Information:

Amount: $25.00

VISA / Master Card / Discover

Card #____________________

CREDIT CARD PAYMENT

Expiration Date: ____/____

Security Code: __________

Cardholder Name: ____

Signature: ____

Remit To:
Pain Management Associates PC
10228 Dupont Circle Dr. E.
Fort Wayne IN. 46825-1611