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Medical Record Release Authorization Form

1. I, _____ DOB: _____ hereby authorize:
   Printed Patient Name — Patient DOB

   a. Interventional Pain Specialist and its associates/employees to use, obtain and/or disclose my protected health information.

   b. Physician's Name: _____ Fax Number: _____
   to release my medical record to **Interventional Pain Specialists and its associates/employees.**

2. Reason for release of medical records (mark a, b, or c below)

   a. _____ Continuation of Care

   b. _____ Insurance Change

   c. _____ Other: _____

3. I hereby authorize (mark a or b below)

   a. _____The release and use of my complete health record.

   OR

   b. _____I hereby authorize the release of and use of my complete health record with the exception of: (check records that you **Do Not** want to send)

      i. _____Alcohol/drug abuse treatment

      ii. _____Communicable Diseases

      iii. _____Mental Health Records

      iv. _____Other: _____

4. I understand that the information released may be disclosed by the recipient and may no longer be protected.

5. I am voluntarily releasing and authorizing the use of information protected by law.

_____
Signature of Patient or Authorized Individual — Date

_____
Printed Name of Patient or Authorized Individual — Relationship to Patient

_____
Witness' Signature — Date