

ADVANCED PAIN CENTERS, S.C.
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Social Security #: _____

I, the undersigned, authorize you to furnish a copy of the following medical records to Advanced Pain Centers, S.C.:

- | | |
|---|---|
| <input checked="" type="checkbox"/> Laboratory Data | <input checked="" type="checkbox"/> Hospital Notes |
| <input checked="" type="checkbox"/> Radiology Reports | <input checked="" type="checkbox"/> ER Notes |
| <input checked="" type="checkbox"/> Progress/Doctor's Notes | <input checked="" type="checkbox"/> Operative reports, findings and complications |
| <input checked="" type="checkbox"/> Pathology reports | |

____ Other documents: Specify: _____

I authorize the release of these medical records to Advanced Pain Centers from all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment.

I authorize Advanced Pain Centers to release my medical records regarding their treatment to relevant healthcare providers, facilities and diagnostic centers involved in the course of my treatment.

I specifically consent to the disclosure of records to Advanced Pain Centers that may contain alcohol/drug or substance abuse information. I specifically consent to the disclosure of these records by Advanced Pain Centers to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____(Initials)

I specifically consent to the disclosure of records to Advanced Pain Centers that may contain HIV test results or diagnoses and AIDs and AIDs related conditions. I specifically consent to the disclosure of these records by Advanced Pain Centers to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____(Initials)

I specifically consent to the disclosure of records that contain mental health information. I specifically consent to the disclosure of these records by Advanced Pain Centers to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. _____(Initials)

If not previously revoked, this authorization will expire TWELVE (12 months) from the date of my signature or as otherwise specified by date, event or condition(s) as follows: _____

Signature

Date

Witness' Signature