MISSION
advanced pain management & spine center

Authorization to Release Medical Records

Patient Name: _____ DOB: _____

Patient's Address: _____

_____

Patient Phone: Home _____ Work: _____ Cell: _____

By signing this authorization, I authorize Mission Advanced Pain Management & Spine Center, P.C. to use and/or disclose medical information concerning my medical treatment including any reference or record relating to my mental health and/or substance abuse to or for the individual and/or party listed below:

Name: _____ Phone _____

Business Name: _____

Address: _____ Fax: _____

_____

Information to be released: (check all applicable)

- ☐ Complete Medical Record
- ☐ Records with specified dates of
- ☐ Other

I understand that the medical records I authorized to be disclosed are privileged and confidential and may be disclosed only on my authorization, except as required by HIPAA and related laws or other disclosures identified in the Notice of Privacy Practices of Mission Advanced Pain Management & Spine Center, P.C.

This Authorization will expire on _____, unless revoked sooner by the Patient or Patient's author-ized Legal Representative. If the undersigned fails to specify an expiration date, event or condition, this authorization will expire 6 months from the date signed.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____ _____

Print Name of Legal Guardian Relationship to Patient

For personal copies of your medical records, charges may apply of 50 cents per page up to 50 pages and 25 cents per page thereafter plus postage if applicable.

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