PAIN MANAGEMENT INSTITUTE
MEDICAL RECORDS - RELEASE OF INFORMATION

Patient Name:	Chart #:	Date:

Name of Institution Holding Records To:	
Address:	
City, State, Zip:	

I AUTHORIZE YOU TO RELEASE RECORDS:

Name of Person/Institution Requesting Records To:	
Address:	
City, State, Zip:	

REASON FOR RELEASING INFORMATION

PORTION OF MEDICAL RECORD TO BE RELEASED
DATE OF SURGERY/SERVICE

Description		Description		Description	
Entire Medical Record		Physician's Orders		Nurse's Notes	
Radiology Report		History & Physical Report		Progress Notes	
Lab Report		Discharge Summary		Procedure Record	
Pathology Report		Anesthesia Record		HIV/Aids Related Med Hx	

Other:

This authorization will remain in effect for six months unless otherwise stipulated by the patient. This authorization can be revoked in writing by the patient at any time, but it is not retroactive to release of information made in good faith.

This information is released in good faith for a specific purpose. No copies of released information may be disclosed to anyone without additional written consent of the person to whom it pertains, unless specified in this authorization. All information released will be stamped with a statement prohibiting re-disclosure.

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand there is a charge for copies and that such charges must be paid prior to the release of records.

Signature of Patient or Legal Guardian:	Birthdate:
Address:	Date:
Printed Name of Person Releasing Records:	
Signature	Date