



Authorization to Release Medical Records

Patient Name: _____ DOB: _____ SSN: _____

Patient's Address: _____

Patient Telephone: Cell: _____
 Home: _____
 Work: _____

By signing this authorization, I authorize The Pain Center of West Virginia 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: _____ Fax: _____

Address: _____

Information to be released:

(Check all applicable)

- Complete Medical Record
- Records of care from the following dates: _____ to _____
- Records concerning the following conditions: _____
- Other, please specify: _____
- Confer with person(s) listed orally about my medical information:

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 privacy policies of The Pain Center of West Virginia. The authorization will expire 6 months from the date signed unless the undersigned specifies an expiration date or event or condition.

 Signature of Patient or Legal Guardian:

 Date:

 Print Patient Name

 Print Name of Legal Guardian

 Relationship to Patient

PLEASE MAIL ANY MEDICAL RECORDS OVER 20 PAGES. THANK YOU.