Authorization for the Release of Medical Information

Instructions: Fill out this form completely. Complete one form per place of service requested.

Print patient name	Daytime telephone	Date of birth

Release information from:	Release information to:
	Arizona Pain Treatment Centers
	1301 E McDowell Road, Suite 100
	Phoenix, AZ 85006
(phone)	602-265-8800 (phone)
(fax)	602-265-8151 (fax)

Please check specific information to be released. Otherwise, your entire chart must be released.

√ Progress notes
√ Operative reports
√ Radiology/diagnostic test reports
□ Lab results
□ Medication list

Date range of information to be released: *Last 3 months at your facility*

The purpose of this request:

√ Further medical care
□ Disability determination
□ Insurance
□ Government agency/Police
□ Attorney/Legal investigation
□ Personal use
□ Other ________________________________

I understand that the information in my health record may include information relating to sexually-transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It also may include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire one year from the date of signature.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

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Patient signature **Print name** **Date**

Office initials _____