Manage your Pain.
Enjoy your Life!

Center for PAIN and REHAB Medicine

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Board Certified in Pain Medicine, Physical Medicine & Rehabilitation

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information:

______________________________________ ____________________ ________________
Name (print) **Date of Birth** **SSN**

Information To Be Released From:
Name of Facility or Provider: ____
Address: ____
Phone#: ______________________________________ Fax#: ______________________________

Information To Be Sent To:
Name of designated recipient: **Center for Pain and Rehabilitation Medicine, PC**
240 Medical Blvd., Stockbridge, GA 30281
Fax# 678-284-6500 Ph# 678-284-4000

Information to be Released: (please check one)
_____All Medical Records
_____The most recent ______ years/month of pertinent information (chart notes, labs, x-rays, and special tests)
_____Specific information (please specify) ____

Purpose for which the disclosure is being made: (please check one)
________ Doctor ________ Attorney ________ Insurance _________ Personal
Other (specify): ____

PATIENT AUTHORIZATION:
I understand that my records may contain information regarding diagnosis or treatment of HIV/AID sexually transmitted diseases, drug and/or alcohol abuse, mental illness, psychiatric treatment.
________ I give my specific authorization for these records to be released. (**please initial**)
***__**EXCLUDE**__ the following information from the records released. (**please initial**)
________ Drug/Alcohol abuse/treatment & diagnosis _________ Sexually transmitted diseases
________ HIV/AIDS diagnosis/treatment/testing _________ Mental Illness or psychiatric diagnosis/treatment

MY RIGHTS:
I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization by notifying Center for Pain and Rehab. Medicine in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy.

Signature ____ Date: __________________________

This authorization will expire 90 days from the date signed. Possible copying fee required.

MR/2015