

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Home address \_\_\_\_\_

Patient phone number \_\_\_\_\_

I hereby authorize Pain and Spine Specialists of Connecticut an affiliate of National Spine and Pain Centers to make uses and disclosures of my protected health information (information about me in my medical records and/or financial records as indicated below:

**Description of information to be disclosed (please check all that apply):**

- |   |  |
|---|--|
| <input type="checkbox"/> Most recent visit note | <input type="checkbox"/> Imaging/EKG     |
| <input type="checkbox"/> Consult report         | <input type="checkbox"/> Test results    |
| <input type="checkbox"/> Entire chart           | <input type="checkbox"/> Procedure notes |

**HIV and mental health information contained within the parts of the records indicated above will be released through this authorization unless otherwise indicated.**

Do NOT release the following:  Drug and Alcohol  HIV  Mental health

**Reason for requested use or disclosure: Continuation of treatment / transfer of care**

**Records to be released to: Pain Management Partners, Dr. David C. Levi and Dr. Robert J. Boolbol**

**Please send the above information to: medicalrecords@pmpct.net**

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- My decision to revoke this authorization does not apply to any release of my records that may have taken place prior to the date of the revocation if the practice has already taken action.
- The practice will not condition treatment, payment, enrollment or eligibility based on my signing of this authorization.
- I am entitled to a copy of this authorization.
- I am not required to sign this authorization to receive treatment.
- This authorization to release information is effective for a period of 90 days from the date of signature, unless otherwise specified here. This authorization is effective until \_\_\_\_\_.

\_\_\_\_\_  
Patient or patient representative signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient representative

\_\_\_\_\_  
If signed by patient representative, relationship to patient