PALOVERDE
PAIN SPECIALISTS

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name_____SSN_____DOB_____

To Provider/Facility Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I, the undersigned, authorize you to furnish a copy of the following medical records.

Covering the Period From: _____ To: _____

To be included:

□ My Diagnosis
□ My Progress
□ Office Notes
□ Hospital Reports
□ Other: _____
□ Lab and Diagnostic Studies
□ Radiographic Films and Reports
□ Emergency Treatment Reports
□ Operative Reports

I authorize this release to:

□ Palo Verde Pain Specialists
13090 N 94th Drive, Suite 212 Peoria, AZ 85381
Office 833-578-7846 Fax 602-714-7176

For the following purpose and that purpose only. Any other use is forbidden.

_____

This authorization specifically authorizes you to disclose records of alcohol abuse and substance abuse. This authorization specifically authorizes you to disclose HIV test results or diagnosis and AIDS and AIDS-related conditions.

I also understand that I may revoke this authorization at any time, except to the extent that Palo Verde Pain Specialists has already taken action in reliance on it.

_____ _____
Signature of Patient or Authorized Legal Representative* Date

_____ _____
Relationship to Patient Witness Signature/Date

** A legal representative includes ONLY 1) the parent of a minor, 2) the court-appointed guardian of a minor or incompetent patient (court order appointing guardian MUST accompany this form), 3) a person or agent for the patient under a durable power of attorney for health care, or 4) the executor or administrator of the estate of a deceased patient (copy of the court order appointing executor or administrator MUST accompany this form).*