SPECIALTY PAIN MANAGEMENT
Treating Your PAIN With Compassion

Authorization for Release of Information

PATIENT	Name: _____ DOB: _____ Maiden or other previous names: _____
HEALTH INFORMATION RELEASED *FROM*	❑ **SPECIALTY PAIN MANAGEMENT** 1466 W. Elliot Rd., Gilbert, AZ 85233 Phone: 480-496-2699 Fax: 1-877-422-3184 ❑ Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
HEALTH INFORMATION RELEASED *TO*	❑ **SPECIALTY PAIN MANAGEMENT** 1466 W. Elliot Rd., Gilbert, AZ 85233 Phone: 480-496-2699 Fax: 1-877-422-3184 ❑ Person/Organization: _____ Address: _____ Phone: _____ Fax: _____
DELIVERY	❑ Fax ❑ Pick up (Fee & Photo ID required) ❑ Other: _____
PURPOSE	❑ Continuity of Care ❑ Insurance ❑ Disability ❑ Legal ❑ Personal ❑ Other
HEALTH INFORMATION TO BE RELEASED	❑ Entire Medical Record ❑ Laboratory Reports ❑ Office Visit Notes ❑ Radiology Reports ❑ Operative/Procedure Notes ❑ Other: _____
DATES OF TREATMENT TO BE RELEASED	❑ Please release 6 months of **most recent** records ❑ Please release 12 months of **most recent** records ❑ Please release records for the period of _____ to _____
AUTHORIZATION/ REVOCATION	This authorization will terminate in one year unless otherwise specified: _____ This signed authorization allows release of the requested records to Specialty Pain Management. Providing the information has not already been disclosed, this release may be revoked at any time by sending a request in writing to our clinic. A photocopy of this signed authorization is as valid as the original. I understand that once the information is released, the information is subject to re-disclosure and may not be protected by the federal privacy regulation. Specialty Pain Management WILLL NOT release records obtained from another health care provider or facility. Patient Signature: _____ Date: _____