PHOENICIAN PAIN CENTER

AUTHORIZATION FOR RELEASE OF RECORDS

IN ORDER TO RELEASE OR OBTAIN YOUR RECORDS, ALL OF THE FOLLOWING INFORMATION MUST BE OBTAINED. IF ANY INFORMATION IS LEFT BLANK, YOUR REQUEST WILL NOT BE PROCESSED.

DATE: ____________
PATIENT'S NAME:____DOB______________
ADDRESS: ____
CITY: __________________STATE:__________________ZIP:_______________________
SSN______-______-_______ DAYTIME PHONE #: (_____) ___________-_________
ARE YOU TRANSFERRING OUT OF OUR FACILTIY? ☐ YES ☐ NO
If yes, reason for leaving practice? ____

I AUTHORIZE Phoenix Neurological & Pain Institute TO:

☐ OBTAIN My Records from ☐ RELEASE My Records To

If releasing records to self, charges will apply

FACILITY NAME: ____
DR'S NAME____
ADDRESS: ____
CITY: ________________________STATE:_______________ZIP:___________________
PHONE (_____) ________-___________ FAX (_______) ________-______________

I HEARBY CONCENT TO THE RELEASE OF ALL MEDICAL RECORDS AND OTHER DOCUMENTATION PERTAINING TO THE MEDICAL CARE RECEIVED IN THIS FACILITY, INCLUDING THE FOLLOWING:

☐ ALL TREATMENT *
☐ LAB REPORTS/X-RAY REPORTS
☐ TREATMENT RELATED TO SPECIFIC INJURY OR ILLNESS ________________________________
☐ BEGINNING AND ENDING DATES OF TREATMENT ________________ TO _________________

**I UNDERSTAND THAT I AM ONLY OBTAINING THE RECORDS PRODUCED BY THIS FACILITY AND NOT THE RECORDS THAT WERE FORWARDED FROM ANY PREVIOUS PRIMARY CARE PHYSICIANS, I SPECIFICALLY CONSENT TO THE RELEASE OF ANY INFO CONTAINED IN THE MEDICAL RECORDS, WHICH MAY RELATE TO THE INFECTION WITH HUMAN IMMINODEFICIENCY VIRUS (HIV), AIDS OR RELATED CONDITIONS, AS WELL AS INFORMATION REGARDED AS CONFIDENTAIL.

** I UNDERSTAND THAT Phoenician Pain Center HAS NO RESPONSIBILITY FOR THE USE OR DISTRUBTION OF THIS INFORMATION BY THE PARTY TO WHOM IT IS RELEASED.I RELEASE PHOENICIAN PAIN CENTER FROM ALL LIABILITY WHICH COULD ARISE FROM THE COMPLIANCE WITH THIS REQUEST TO RELEASE RECORDS. I AUTHORIZE PHOENICIAN PAIN CENTER TO TRANSMIT THIS INFORMATION BY FACSIMILE TRANSMISSION (FAX) AND/OR MAIL AND RELEASE PHOENICIAN PAIN CENTER FROM ANY LIABILITY FOR POTENIAL BREACH OF CONFIDENTIALITY DUE TO MISDIRECTION OF TRANSMISSION OR FAILURE TO RECEIVE TRANSMISSION OF MY RECORDS.

PATIENT SIGNATURE: ____DATE:___________