CONSULTANTS IN PAIN MEDICINE, PIMA PAIN CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

P: 520-399-6000

Patient Name: _____ DOB: _____ Social Security #_____

I hereby authorize the release of my medical records to:

Consultants in Pain Medicine, PIMA PAIN CENTER. Fax: 520-399-6002

Requesting medical records from: (please enter complete address)

DR _____

_____

_____

ATTN: MEDICAL RELEASE DEPARTMENT

PH: _____ FX:_____

Please Check; Labs ☐ X-Rays ☐ CTs ☐ MRIs ☐

CURRENT All That Apply: ; ☐ Last 3 Progress Notes ☐ All Medical Records

Other: ☐ MEDICATION LIST AND LABS

Patient Signature: _____ Date: _____

This authorization will automatically expire two (2) years from the date signed.

*In order to comply with regulation for Health Insurance Portability and Accountability Act (HIPAA) governing the confidentiality of patient information, a fully completed, HIPAA compliant, Authorization to Release Medical Records must accompany each request for medical records even though you may have already obtained a signed consent from the patient. We are sorry for any inconvenience this may cause, but the laws were enacted to protect the confidentiality of medical information. Physician must comply with HIPAA privacy standards by Requiring a fully completed form with all required information before releasing patient information. Thank you for your cooperation