UNITED PAIN CENTER

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL RECORDS

Treatment will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize and request:

_____

(Name of Healthcare Provider, Phone, Fax)

To release medical records in their possession

TO: UNITED PAIN CENTER Fax: (951) 698-0272

Release and/or disclose records and information regarding:

_____ /

Name of Patient **Date of Birth**

SPECIFIC RECORDS TO BE RELEASED AND/OR DISCLOSED:

[ ] General Medical Information **[ ] Labs**

[ ] Radiology: CT, Ultrasound, MRI **[ ] Other:**

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. This copy is for me to keep.

_____ _____ _____

Signature of Patient or Pt Representative Relationship Date

DISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.