APS | Atlanta Pain & Spine Physicians

MEDICAL RECORDS REQUEST/RELEASE
PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FROM ATLANTA PAIN AND SPINE PHYSICIANS

I have read this authorization and understand what information will be released, who may use this information, and who is going to receive this information. I understand this form and that I retain the right to revoke this authorization at any time.

I authorize any current employee or owner of Atlanta Pain and Spine Physicians

To release or disclose the following information:

(x) last 3 office visits or progress notes
(x) all notes for the past 2 years that are related to any pain management procedures
(x) my complete medication profile
(x) any MRI/CT reports related to the patients pain condition
(x) any results from lab/radiology pertinent to care/condition
(x) other _____

To: Name: _____

Mailing Address: _____

_____

_____

Or Faxed to Fax Number: _____

_____
Patients Printed Name

_____
Patients Date of Birth

_____
Patients Signature

_____
Today's Date

Records Sent Via Fax to the above listed fax number OR mailed to the above indicated address by:

_____
Employee Signature

_____
Date

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