ADVANCED PAIN CENTERS, S.C.
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________ Date of Birth: ______________

Social Security #: ____________________________

I, the undersigned, authorize you to furnish a copy of the following medical records to Advanced Pain Centers, S.C.:

- [x] Laboratory Data
- [x] Hospital Notes
- [x] Radiology Reports
- [x] ER Notes
- [x] Progress/Doctor's Notes
- [x] Operative reports, findings and complications
- [x] Pathology reports
- [x] Other documents: Specify: ALL RECORDS, INCLUDING BEHAVIORAL HEALTH.

I authorize the release of these medical records to Advanced Pain Centers from all physicians, relevant healthcare facilities and diagnostic centers involved in the course of my treatment.

I authorize Advanced Pain Centers to release my medical records regarding their treatment to relevant healthcare providers, facilities and diagnostic centers involved in the course of my treatment.

I specifically consent to the disclosure of records to Advanced Pain Centers that may contain alcohol/drug or substance abuse information. I specifically consent to the disclosure of these records by Advanced Pain Centers to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. ________**(Initials)**

I specifically consent to the disclosure of records to Advanced Pain Centers that may contain HIV test results or diagnoses and AIDs and AIDs related conditions. I specifically consent to the disclosure of these records by Advanced Pain Centers to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. ________**(Initials)**

I specifically consent to the disclosure of records that contain mental health information. I specifically consent to the disclosure of these records by Advanced Pain Centers to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment. ________**(Initials)**

If not previously revoked, this authorization will expire TWELVE (12 months) from the date of my signature or as otherwise specified by date, event or condition(s) as follows:: ______________________________

____.

______________________________ Signature

______________________ Date

______________________________ Witness' Signature

White Copy - OFFICE **Yellow Copy - PATIENT**

Revised 01/01/06