Authorization to Release Medical Records

I hereby authorize the release of my medical records **from Portland Pain Solutions, LLC.**

Patient name: _(or see barcode above)_____

Address: _____

Date of birth: _____ Medical record #:_____

Date(s) of treatment: ALL ( ) OTHER ( ):_____

Release information to:_____
_____

Address: _____

Phone: _____Fax:_____

Email: _____

INFORMATION TO BE RELEASED OR ACCESSED (please check all if you are being seen as a new patient):
___Office Clinical Notes ___ Procedure Notes ___Lab/ Path Reports
___Medical Imaging Reports

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
The Authorization will expire six(6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Patient/Guardian Signature: _____

Relation to Patient (if legal representative or guardian): _____

PORTLAND PAIN SOLUTIONS
Spine & Orthopedics

PORTLAND PAIN SOLUTIONS
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