Medical Release Form

Authorization to Request and Release Protected Health Information

PATIENTS: Please complete the Patient Information section of this form ONLY.

	RECEIVING PARTY	

PLEASE RELEASE A COPY OF MY MEDICAL RECORDS TO:

Advanced Spine & Pain Interventions, LLC
12389 Crabapple Rd.
Alpharetta, GA 30004
Phone: (470) 299-1998
Fax: (855) 872-3578

Name of facility or physician requesting records from:

_____
_

Address:

_____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number:_____

	PATIENT INFORMATION	

Patient Name:

_____

Address:

_____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Phone Number: _____

**Please check the appropriate box, and initial on the lines provided below.*

Information allowed to be released/disclosed:

□ Full Medical Record

Other:_____

_____ I understand that my disclosed medical records may include confidential information related to infectious and communicable diseases (e.g., HIV, AIDS), behavioral or mental health, and/or treatment for alcohol and drug abuse.

_____ I understand that I may revoke this authorization except to the extent that it has already been acted upon. Treatment will not be conditioned on me providing this authorization, unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party. Once this information is released, it may be disclosed by the recipient. I can request a copy of this signed authorized from Advanced Spine & Pain Interventions, LLC at any time. This Medical Release Form must be completed before information is released. Unless otherwise revoked, this authorization will expire one year from the date signed.

Patient Signature: _____ Date: _____