253 Lewis Lane, Suite 302, Havre de Grace, MD 21078   Phone:410.942.0620 Fax :410.939.2080

MEDICAL RECORDS REQUEST RELEASE

Patient's Name: ____

Date of Birth: ____

Street Address: ____

City, State, Zip Code: ____

Telephone Number: ____

I hereby request that my Medical Records be released to:

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TO BE SUBMITTED TO:

Sports & Spine Pain Management
253 Lewis Lane, Suite 302
Havre de Grace, MD 21078
Phone: 410-942-0620
Fax: 410-939-2080

Revocation:
I hereby authorize the Provider to release Protected Health Information to Sports & Spine Pain Management. I understand that this authorization may cover information relating to: (I) AIDS, HIV and other communicable diseases; (II) genetic testing; (III) psychiatric, mental and behavioral health and treatment; and (IV) alcohol, drug and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that my signature is valid for up to one year from the date signed below. I understand that I can request, in writing, that the authorization be cancelled at any time. I do not authorize re-release of this information to anyone. A copy of the authorization is as valid as the original. I understand that once Sports & Spine Pain Management has disclosed the health care information I have authorized, Sports & Spine Pain Management has no control over the information and that this information may no longer be protected by privacy laws. Sports & Spine Pain Management will not condition treatment for any patient that refuses to sign an authorization for release of Protected Health Information.

Authorization:

Patient's Signature: ___________________________________Date:______________________________

Specific Request:

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