Addison Pain
+ Regenerative Medicine

Medical Records Release Authorization

I hereby authorize the use of disclosure of information from the medical record of

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

PLEASE RELEASE THE FOLLOWING INFORMATION

☐ **Entire Record** ☐ Progress Notes ☐ Radiology Reports
☐ Laboratory Results ☐ Medication List ☐ Other: ______________________

TO THE FOLLOWING RECIPIENT

☐ Directly to patient
☐ Healthcare provider / facility: ______________________
Fax: ______________________ Email: ______________________
☐ Other: ______________________
Fax: ______________________ Email: ______________________

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse. I understand that I have a right to revoke this authorization at any time and must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already release in response to this authorization. I understand that any disclosure information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that my medical record may contain notes and results that only a physician can interpret. I understand and have been advised that I should contact my physician to prevent my misunderstanding the information contained in these entries. I will not hold East Rehabilitation P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

______________________ ______________________
Patient Signature **Date**