**Phone**: 206-538-6300
**Fax**: 206-538-6301

ANESIS
SPINE & PAIN CARE
MEDICAL SERVICES PROVIDED BY PAIN CARE PHYSICIANS, PLLC

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**PATIENT NAME (Please Print: First, MI, Last)** **DATE OF BIRTH**

☐ I authorize Pain Care Physicians, PLLC to use and disclose my protected health information.

**Information to be:** (Check one) ☐ **Sent to** ☐ **Requested from**

**Name of Facility, MD, Other**

**Fax Number** **Phone Number**

**Address City, State, Zip**

**Information requested/to be disclosed**: (Please give specific dates of service if possible)_____

**I authorize the release of the following complete health records:**

☐ **XR REPORT** - (BODY PART) _____
☐ **CT REPORT** - (BODY PART)_____
☐ **MRI REPORT** - (BODY PART) _____
☐ **LAB WORK** - (TYPE) _____
☐ **PROCEDURE/OP REPORT** - (TYPE) _____
☐ **ER RECORDS** - (DATES)_____
☐ **PHYSICAL THERAPY REPORT**
☐ **LAST 3 CHART NOTES from** _____
☐ **EMG**
☐ **Other (please specify):** _____

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying Pain Care Physicians, PLLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.
- Pain Care Physicians, PLLC may also share any/all information with any local, state and/or federal authorities in the prevention of any illegal drug diversion. I understand that by approving the release of information in the form of a fax that confidentiality cannot be assured I accept the risk that confidentiality may be breached when faxing information. I hereby release Pain Care Physicians, PLLC and its employees from any and all liability that may arise from the release of this information.
- Authorization expires within 90 days from the date this form is signed unless otherwise notified in writing, I understand that any information released prior to written notification to cancel request cannot be reversed and my revocation will not affect those icons.

**PLEASE NOTE**: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals or other care facilities must be obtained directly from those other providers or facilities.

_____ _____

**Patient Signature** **Date Signed**

Fax Request or Records to 206-538-6301 or Email medrec@anesispain.com