Authorization to Release Medical Records

Patient Information:
Full Name: _____
Date of Birth: _____
Address: _____
City, State, ZIP: _____
Phone Number: _____
Email: _____

I, the undersigned, hereby authorize the release of my medical records to:

Center for Interventional Pain & Spine
291 Carter Dr., STE A
Middletown, DE 19709
(P) 844-365-7246
(F) 844-516-0080

1. Purpose of Disclosure (check all that apply):
   [ ] Treatment
   [ ] Insurance Claim
   [ ] Legal Proceedings
   [ ] Personal Records
   [ ] Other (please specify): _____

2. Specific Information to Be Disclosed (check all that apply):
   [ ] All Medical Records
   [ ] Specific Dates of Treatment: From _____ To _____
   [ ] Specific Information (describe): _____

3. Consent Validity Period (check one):
   [ ] This authorization is valid for a one-time disclosure.
   [ ] This authorization is valid for a period of ____ months/years.

4. Additional Information/Instructions (if any): _____

5. I understand that my records may include information about my medical history, diagnosis, treatment, and other healthcare-related information. I acknowledge that this information will be disclosed to the recipient mentioned above.

6. I have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this authorization. To revoke, I must provide written notice to the healthcare facility.

7. This authorization complies with all applicable federal and state laws regarding the release of medical records, including the Health Insurance Portability and Accountability Act (HIPAA).

Patient's Signature: _____ Date: _____

If this authorization is not signed by the patient, please provide the relationship to the patient and legal authority to act on their behalf:

Relationship: _____ Legal Authority: _____

Witness (if required by state law):
Name: _____ Signature: _____
Date: _____