Valley Pain Specialists, PC
4250 Fritch Dr
Bethelehem, PA 18020
610-954-9040 tel
610-954-9093 fax

Patient Authorization for Release of Medical Records

Patient's Name:
Address:

DOB:

Please check all information that applies:
☐ Chart Notes-entire record
☐ Chart Notes for the period of ___/___/_____ to ____/___/_____
(Please note if you are establishing your care elsewhere, they may not want your ENTIRE record. Please specify the exact time span above)
☐ MRI report
☐ X-rays
☐ CAT Scan
☐ Other (please specify):

Please include dates, body side and body part:

☐ I want Valley Pain Specialists to receive my records. Therefore, I give my authorization to have the above protected information released to VALLEY PAIN SPECIALISTS, PC

☐ I want Valley Pain Specialists to send my records to another medical provider. Therefore, I am authorizing VALLEY PAIN SPECIALISTS, PC to disclose or release the above protected health information to the following person or organization. The following will receive and use my protected health information:

Name:
Address:
Fax #:

Select one of the following choices:
☐ This authorization will end on the following date:
☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

Signature of Patient: _____

_____
Name of Patient: (date)