M.D. Pain Specialists

Transformation through evidence based care

Phone: (760) 734-1800
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www.mdpainspecialist.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize ______________________________, or other treating physician/provider at the facility to furnish medical information concerning ____ (patient).

To:

1680 S Melrose	2027 Grand Canal Blvd	100 E Romie Lane
Suite 105	Suite 29	Suite 4
Vista, CA 92081	Stockton, CA 95207	Salinas, CA 93901

Any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records, if any, except as specifically provided below:

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The information may be used only for the following purposes:

Diagnosis, treatment, management of acute and chronic painful conditions,
or other: ____

This authorization is effective now and will remain effective until __________________ (date)

I understand that I have the right to receive a copy of this authorization.

Signed ____ Dated __________________

Print Name ____

If not signed by the patient, please indicate the relationship:

- ❑ Patent or guardian of minor patient (to the extent minor child could not have consented to the care)
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient
- ❑ Spouse or person financially responsible (where information is solely for the purpose of processing applications for dependant health care coverage)

*Signed ____ Dated __________________

For the release of records (1) proctected by the Lanterman-Petris_Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Both patient and treating physician must sign for before information may be released.