



### Medical Record Authorization for Request/Release of Information

I hereby authorize Midwest Pain Institute personnel to  send or to  receive my medical records and/or x-rays.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_mo..\_\_day\_\_yr.

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Send Information to:**

\_\_\_\_\_  
(Name of person/ organization) Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_

\_\_\_\_\_  
(Address of person/ organization) Fax # (\_\_\_\_) \_\_\_\_-\_\_\_\_

**Receive Information from:**

\_\_\_\_\_  
(Name of person/ organization information is being requested from) Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_

\_\_\_\_\_  
Fax # (\_\_\_\_) \_\_\_\_-\_\_\_\_

I understand that I may REVOKE this release at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, EXCEPT to the extent that action has been taken thereon. I also understand that this release may include medical records of treatment for physical and/or mental illness, including treatment of alcohol or drug abuse. Unless the "No" line is initialed, this request also extends to communicable disease, including human immunodeficiency syndrome (HIV), if contained in the said medical record. A facsimile signature will be considered an original for this purpose.

No: \_\_\_\_\_

**Current Medical Information to be  Released  Requested:**

\_\_\_ Entire Medical Record      \_\_\_ Most Recent Office Notes      \_\_\_ Diagnostic Reports

Other: \_\_\_\_\_

X \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient Signature*

X \_\_\_\_\_  
*Relationship if signed by someone other than patient*

Witness: \_\_\_\_\_ Date: \_\_\_\_\_