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Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: ____ / ____ / _____
SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: () _____ Email: _____

I, _____, hereby authorize Temecula Pain Management to
(name)

___ obtain from the following facility / person ___ release to the following facility / person

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: () _____ Fax: () _____ Email _____

Records to send: _____

- Exclusions:
- ___ Mental Health Records
 - ___ Substance Abuse Treatment Records
 - ___ HIV/AIDS-related information
 - ___ Genetic Testing Information
 - ___ Sexual Transmitted Disease Information
 - ___ Reproductive Health Information

By signing below, I hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information to the physician / person / facility / entity listed above.

Signature

Date