



## Medical Records Release/Request Form

(Check One)

**Release** \_\_\_\_\_ Releasing information from us to you or your provider

**Request** \_\_\_\_\_ Requesting information from another provider to us

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

**I authorize** Pain Management Associates/KC Pain Centers to (circle one) **Release** / **Request** the following:

Information Requested \_\_\_\_\_

Purpose of Request \_\_\_\_\_

**Release To:**

**Request From:**

\_\_\_\_\_  
(indicate Self or other party to receive records)

\_\_\_\_\_  
(Facility/party from which information should be obtained)

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone/Fax# \_\_\_\_\_

Phone/Fax# \_\_\_\_\_

- I understand that this authorization shall be valid through \_\_\_\_\_ (date), or one year from the signing of this authorization, but that I may revoke it IN WRITING at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may NOT be re-released to any other person or organization not affiliated with my care without my written consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witnessed by \_\_\_\_\_ Date \_\_\_\_\_