



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 _____