
**AUTHORIZATION TO OBTAIN MEDICAL RECORDS**

1967 NJ-34, Suite 102, Wall Township, NJ 07719
Phone: 732-345-1180 | Fax: 732-530-4476

Patient's Name:_____ Date of Birth:_____

I request and authorize Spine and Pain Centers to obtain my protected health information from:

Name:_____

Address:_____

Fax:_____

The information to be released is to include: (indicate dates of treatment and portion of each to be released).

_____Reports of Operation
_____Consultation Reports
_____Radiologic Interpretation
_____Lab Test Results

Yes___ No____ I authorize the release of any records regarding drug, alcohol, mental health treatment to the person(s) listed above. If you do not make a selection, these records will be released as part of your records.

Unless otherwise revoked by myself, this authorization is to be considered valid only for 30 days from the date below. If information has been released under the terms of this authorization which I later revoke, I understand that Spine and Pain Centers will not be responsible for release prior to receipt of revocation.

Date: _____ Patient Signature: _____