Dr. Chi-Shin Jason Chiu MD, DABA
1608 Lemoine Avenue, Suite 101
Fort Lee, NJ 07024
Tel: 201-592-7246 Fax: 201-540-9978

Medical Record Release Form

Send To: _____ **Via Fax**: _____

_____

_____

Patient Name: _____ DOB: _____

This shall serve as an authorization to release copies of my medical record to **The Painless Center, LLC.** I understand that the release of my information to **The Painless Center, LLC** will aid in the continuation of my care and allows me to receive further treatment if necessary. **The Painless Center, LLC** follows HIPAA compliance in the handling of pertinent patient medical information. I hereby authorize the release of my records including but not limited to the following:

- ☐Demographic Information
- ☐Clinical notes/Medication history/Operative reports
- ☐Radiology/Imaging/MRI/CT Scan/X-ray
- ☐Lab results/Urine drug screen/Routine blood test

- ☐Other: _____

Patient Signature: _____ **Date**: _____

Please send records via fax**: 201-540-9978** or via email: **admin@thepainlesscenter.com**

Thank you, in advance, for your cooperation!