AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I ____________________________ hereby authorize ___________________________

Patient **Medical Doctor/Office/Facility**

to release to Balanced Pain Management the Medical Record(s) in the custody of the _____________________________, including applicable mental health records.

Medical Doctor/Office/Facility

This authorization for release of information may be revoked or withdrawn at any time and revocation or withdrawal will apply to all information not previously released to Balanced Pain Management. This information will expire one year following the date indicated below and the expiration will apply to all information obtained if it is determined to be necessary in order to complete a review of your Records. This information will be confidential.

______________________________________ ______________________

Print Name **Date**

______________________________________ ______________________

Signature **Date**

If completing on behalf of another adult, a signature is required from that individual. If you have Power of Attorney on behalf of another individual, please provide us with a copy of the legal document.

Please sign the Authorization of Release of Medical Records. Attach copies of all relevant documents and records, as original cannot be returned.

Fax these documents to: (925) 988-9335 or call: (925) 988-9333

Mail to:

Leslie R. Delaney, M.D.
Balanced Pain Management
114 La Casa Via, Suite 210
Walnut Creek, CA 94598