

Release of Medical Information Form



IT TAKES A

VILLAGE

RELEASE OF MEDICAL INFORMATION

(For Release to/from Physicians, healthcare institutions, pharmacies, insurance companies, and Legal counsel, other: _____)

I, _____ Date of birth _____ Sex _____.

Authorize It Takes a Village Pain Management Practice of New York (ITAV) to obtain my medical information from other physicians/above named as necessary for my continuing care and treatment.

Information requested:

- Lumbar MRI report
- Cervical MRI report
- most recent note
- most recent imaging
- notes from last 3 months

Other: _____

I authorize ITAV Pain management to release to above named and as per the privacy notice any and all findings and information in connection with my examinations, care, and treatment at ITAV Pain Management.

Signature: _____ **Date:** _____

Parent/Legal Guardian where applicable: _____

Witness: _____ **Date:** _____

Send records to: ITAV pain management, 1181 Old country Road Ste1, Plainview, NY, 11803

Fax: 518-240-1205