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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

- **Healthcare information relating to the following treatment, condition, or dates:**

REPORTS: ☐ CT SCAN ☐ MRI ☐ X-RAYS ☐ PET SCAN ☐ MOST RECENT OFFICE VISIT NOTES
☐ REFERRAL ☐ EMG/NCS ☐ OTHER: _____

OTHER: ☐ COPY INSURANCE CARD ☐ COPY DEMOGRAPHIC SHEET

- **Other:** PAIN MANAGEMENT INTERVENTION: (Physical Therapy, Medication, TENS, Surgery, Injections)

Definition: The patient's most recent medical records with specific correlation to the patient's pain

☐ **Yes** ☐ **No** **I authorize the release of my medical records**

☐ **Yes** ☐ **No** **I authorize the release of any records regarding drug, alcohol, mental health, or STD treatment, to the person(s) listed above.**

Patient Signature: _____ Date Signed: _____

NOTICE TO RECIPIENT OF INFORMATION:

This information has been disclosed in accordance with Subtitle 3 of 4 of the Annotated Code of Maryland. Any individual of agency receiving this information is prohibited from making further disclosure of this information (Federal Regulation 42 CFR Part 2) as provided by 4-303(b)(5)(ii). If this information concerns a person admitted for treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law and prohibits further disclosure of this information except with specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose.