VALLEY PAIN CONSULTANTS
An Envision Physician Services Provider

Phone (480) 467-2273
Fax (602) 648-4361

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ **DOB:** _____

ADDRESS: _____

PURPOSE OF DISCLOSURE: _____

☐ PLEASE RELEASE **ALL** MEDICAL INFORMATION
(WHICH MAY INCLUDE PSYCHIATRIC COUNSELING. DRUG OR ALCOHOL TREATMENT, AND HIV/AIDS RELATED INFORMATION AND CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION.)

☐ PLEASE RELEASE **ONLY** THE FOLLOWING SPECIFIC INFORMATION: _____

_____

I HEREBY AUTHORIZE VALLEY PAIN CONSULTANTS (circle one) **TO OBTAIN / RELEASE ALL OF THE REQUESTED INFORMATION RELATIVE TO MY TREATMENT AND CARE** (circle one) **FROM / TO**:

NAME OF COMPANY, PERSON, FACILITY: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

I UNDERSTAND THAT BY SIGNING THIS REQUEST FOR THE RECORDS KEPT BY VALLEY PAIN CONSULTANTS FOR MY CARE AND TREATMENT; I WAIVE ANY SUBSEQUENT CLAIM I MAY HAVE FOR ANY BREACH OF CONFIDENTIALITY THAT MAY OCCUR FROM ANY LOSS OR MISPLACEMENT OF THE COPY OF SAID RECORDS ONCE WE HAVE PRODUCED THEM.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION BASED ON THIS AUTHORIZATION HAS ALREADY BEEN TAKEN THIS CONSENT WILL EXPIRE AUTOMATICALLY **ONE YEAR** FROM THE DATE ON WHICH IT IS SIGNED. ANY FURTHER DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS NOT AUTHORIZED WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.

I UNDERSTAND THAT ANY SUBSUQUENT REQUEST FOR RECORDS BY ME, OR ON MY BEHALF, WILL BE CHARGED A COPYING FEE OF FIFTEEN CENTS (.15) PER PAGE.

SIGNATURE OF PATIENT: _____ DATE: _____

WITNESS: _____ DATE: _____

SIGNATURE OF OTHER AUTHORIZED PERSON (IF APPLICABLE) _____

RELATIONSHIP TO PATIENT: _____