PATIENT REQUEST FOR RELEASE OF MEDICAL INFORMATION

SECTION I: PATIENT INFORMATION

Name:	Date of Birth:
Address:	Social Security #
Phone #	

SECTION II: REQUEST FOR SPECIFIC ITEMS TO BE RELEASED

I request Interventional Pain Physicians of South Florida to release the medical information identified below relating to my treatment during these dates: from _____ to _____

Cardiovascular Reports	Emergency Room	Pathology Report	Consultation Report
History & Physical	Progress Note	Discharge Summary	Laboratory Results
X-Ray Reports	EKG Report	Operative Report	Complete Medical Record (will not be faxed)
Photographs, videotapes or other digital images		Records of Prescription Medications	

__ Other (describe):

SECTION III: DELIVERY METHOD

❑ Hold record for pick-up, I personally will claim the record	❑ Fax to this number: *(NOTE: Complete medical record will not be faxed)*
❑ Hold for pick-up by my authorized representative: Name: _____ (NOTE: Your authorized representative will be asked to produce proof of positive identification)	❑ Mail to this address:

SECTION IV: DUPLICATING FEES

I understand:
(1) There is no charge associated with having my records sent directly to another physician or provider to facilitate the continuity or transfer of my care.

(2) This request may take up to ten days to satisfy. _____ (initial)

SECTION V: RELEASE

I hereby release Interventional Pain Physicians of South Florida and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____

Signature of Patient or Legal Guardian Date