**APS** Atlanta Pain & Spine *Physicians*

# MEDICAL RECORDS REQUEST/RELEASE
# PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
# TO ATLANTA PAIN AND SPINE PHYSICIANS

I have read this authorization and understand what information will be released, who may use this information, and who is going to receive this information. I understand this form and that I retain the right to revoke this authorization at any time.

**I authorize** any current employee or owner of ______________________________________________

**To release or disclose the following information**

(x) last 3 office visits or progress notes
(x) all notes for the past 2 years that are related to any pain management procedures
(x) my complete medication profile
(x) any MRI/CT reports related to the patients pain condition
(x) any results from lab/radiology pertinent to care/condition
(x) other __________________________________________

**To:** **Atlanta Pain and Spine Physicians**
**3200 Highlands Parkway #420**
**Smyrna, GA 30082**

**770-436-4450 Phone**
**770-790-4811 Fax**

**Please fax or mail the above information.**

________________________________________
**Patients Printed Name**

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**Patients Date of Birth**

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**Patients Signature**

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**Today's Date**