Authorization to Release Medical Records

to another facility

I, _____, authorize Georgia Pain and Spine Care to release my medical records to the following person or organization.

Mail or Fax records to: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Fax Number: _____ Fax to Attn of: _____

Please note: All faxes must be sent with HIPPA Fax Cover Sheet.

I understand this information will include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: **__N/A__**

Patient's Name: _____

SSN#: __xxx-xx-_____ DOB: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____