AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____

Street Address____

City State Zip ____

Date of Birth: _______________ Social Security No. ___________________

I hereby authorize:

Interventions in Pain Management
4110 Blackhawk Rd Ste 2
Rock Island IL 61201
Phone: 309.428.7055 Fax: 877.811.0028

To disclose any information contained in my medical records to:

Physician/Individual:____

Street Address: ____

City State Zip ____

Phone #: FAX # ____

The extent or nature of the information to be disclosed is:

_______ History & Physical treatment records, initial evaluation reports, progress notes, alcohol and drug abuse records, and surgery reports. This authorization also allows release of psychological service records and social services records, if any.

_______Other tests, X-ray reports, special studies with any or all diagnostic tests: MRI, EKG, EEG, NCS, EMG, Myelogram, CT Scans, Nerve Blocks, etc.

Although I may revoke this authorization at any time (not retro-actively) it will expire in 90 days, or on the date set forth.

____ ________________
Patient/Parent/Legal Guardian's Signature Date

____ ________________
Witness Signature Date