**MEDICAL RECORDS RELEASE**

**FROM GEORGIA PAIN AND SPINE CARE**

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:

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

I understand that 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:

Patient's Name: Patient's Acct #:

SSN: DOB:

Patient's Signature: Date:

Witness: Date:

*This form is valid for one year from patient signature date.*