



Medical Advanced Pain Specialists (MAPS)

Specializing in the art, science, and technology of pain relief and rehabilitation

Medical Advanced Pain Specialists
Release of Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

I authorize and request that a copy of the following medical information be released and disclosed by Medical Advanced Pain Specialists (please check appropriate box):

- All medical information from the following time period: ___/___/___ through ___/___/___
Behavioral Health Records (This box must be checked if you are requesting to be released)
Physical Therapy records only
Other: (explain) _____

I hereby authorize the following person / entity to receive the information:

Name: _____

Address: _____

City: _____ State _____ Zip Code _____

The information is to be released for the following reason (please check the appropriate box):

- Review my current medical care
Continuing care
Insurance claim(s)
Litigation
Other (explain) _____

I understand that once the information is released, the information is subject to re-disclosure and may not be protected by the federal privacy regulation. Information not originated by MAPS cannot be released to another facility.

I understand that this authorization will expire in one year from the date signed below. This form may be revoked at any time providing the information has not already been disclosed.

(Signature of Patient or Representative) _____ (Date) _____
If Representative, specify relation to patient _____