# Pain Consultants of San Diego

Michael Verdolin, MD

## Medical Record Release From

Patient Name:_____DOB:_____

Phone Number:_____Soc Sec#:_____

Release from:_____

Phone:_____Fax:_____

Address:_____

_____

_____

Release to:_____

Phone:_____Fax:_____

Address:_____

_____

_____

- Your records will be forwarded as requested. Please indicate if there are specific dates of service you wish to be sent.
- Please note "All Records" will not be considered specific.
- Is this section is left blank or is unspecific, we will send an abstract summary of your pertinent medical history.

Date of treatments/Visits:_____- _____

Reason For Release:_____

- If your record contains protected health information and you **DO** want this information released, you **MUST** initial in the appropriate space provided next to each choice.

_____HIV/STD related Information _____Mental Health related information _____Drug and Alcohol related information

- I understand that this authorization is subject to revocation at any time.
- I understand that a photocopy or facsimile of this authorization will be considered valid as original.
- I understand that this authorization will expire 90 days from the date of signature and is only valid if its filled out completely.
- I will be solely responsible for any delay caused by failure to complete this form accurately and entirely.
- I understand that a copy of this requested record will be sent to the destination I have specified above.

**I HEREBY ACKNOWLEDGE THAT THIS AUTHORIZATION THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF THE RECORDS FOR THE PURPOSES STATED ABOVE.**

Signature:_____Date:_____

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