Authorization for Release of Medical Record Information
FROM Nevada Pain & Spine Specialists

Patient Name:_____ **Date of Birth:**_____

Information to be released from: Nevada Pain & Spine Specialists (must have signed transfer of records from Sierra Anesthesia/Sierra Pain Consultants-if records requested are prior to November 2006.)
Address: 605 Sierra Rose Drive, Suite 4, Reno NV 89511
Phone: 775-689-5410 ext. 148 Fax: 775-689-5432 –Medical Records

Information to be released to:
Name/Agency:_____
Address:_____

Purpose of Release:_____

INTIAL each item of information to be released.

____**Entire Medical Record**
____**Psychiatric/Psychological/Mental Health Records**
____History & Physical
____Operative/Procedure Reports ____Billing
____Lab/X-Ray/EKG/EMG/Tests ____**Drug and /or Alcohol Abuse Reports**
____Consultation ____Other
_____**AIDS-related information (Full Signature required)**

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this Authorization expires ***1 year*** from the date of signing.
I further release my attending provider and employees of Nevada Pain and Spine Specialists from any liability arising from the release of information to the person/agency designated above.

_____DATE:_____
Signature of Patient

_____DATE:_____
Signature of Part/Legal Guardian/Representative

Relationship to Patient

_____DATE:_____
Signature of Witness

REQUESTOR: (EXCLUDE DR'S OFFICE)
ALL REQUEST WILL BE PROCESSED WITHIN 15 TO 30 BUSINESS DAYS. AFTER 15 PAGES, THE CHARGE FOR OBTAINING MEDICAL RECORDS IS $0.60/PAGE.