AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION
TO *NEVADA PAIN & SPINE SPECIALISTS*

Patient Name _____ Date of Birth_____

Information to be released to:
Nevada Pain & Spine Specialists
Address: 605 Sierra Rose Drive, Suite 4, Reno, NV 89511
Phone: (775) 689-5410
Fax: (775) 689-5432

Information to be released from:

Name/Agency_____

Address_____

_____

Purpose of Release:_____

_____

INITIAL each item of information to be released.

_____Entire Medical Record
_____History & Physical
_____Operative/Procedure Reports
_____Lab/X-Ray/EKG/EMG/Tests
_____Consultation
_____Psychiatric/Psychological/Mental Health Records
_____Drug and/or Alcohol Abuse Records
_____Billing
_____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 ninety (90) days from the date of signing.

I further release my attending provider and employees of Nevada Pain & Spine Specialists from any liability arising from the release of information to the person/agency designated above.

_____Date_____
Signature of Patient

_____Date_____
Signature of Parent/Legal Guardian/Representative

_____
Relationship to Patient

_____Date_____
Signature of Witness