Center *for* Pain Management

Interventional Treatment
For Acute, Chronic & Cancer Pain

SARTELL
166 19th Street South, Suite 101, Sartell, MN 56377
Office: 320-230-7788 Fax: 320-230-7789
BAXTER
15620 Edgewood Drive, Suite 200, Baxter, MN 56401
Office: 218-270-3111 Fax: 218-270-3024
ALEXANDRIA
519 22nd Avenue East, Alexandria, MN 56308
Office: 320-219-7611 Fax: 320-219-7612
BEMIDJI
2300 24TH St NW, Suite 101, Bemidji, MN 56601
Office 218-444-2624 Fax: 218-444-6768

www.centerforpainmanagement.org

Release of Records

Patient: Please Print	Name			Date of Birth
	Other Previous Names:			
Healthcare Facility and/or Provider: WHO WILL RELEASE information?	Name of Facility and Physician			
	Address	City	State	Zip
	Phone Number:	Fax Number:		
Requesting Party: WHO WILL RECEIVE information?	Name of Facility and Physician		Attention:	
	Address	City	State	Zip
	Phone Number:	Fax Number:		
Information to be Disclosed:	_____ History and Physical Exams _____ Discharge Summary _____ Clinic Notes _____ Emergency Room Reports _____ Consultation Reports _____ Lab Reports _____ Hospital and Operative Reports _____ Pathology Reports _____ Films _____ EKG/ECHO Reports _____ Electronic Medical Record review _____ Other _____ **ALL RECORDS *Includes HIV/AIS, Alcohol, Psychiatric and/or Drug Treatment.** _____ **SPECIFIC DATES or TREATMENTS:**			
Exception	_____ **PLEASE MARK** if requesting **RESTRICTION** of records for HIV/AIDS, Alcohol, Psychiatric and/or Drug Treatment or Specify restrictions:			
Reason for Disclosure:	_____ Continued Care by another provider _____ Insurance Claim Purposes _____ Personal Use _____ Attorney Review _____ Other:			
Revocation:	I understand that my signature is valid for up to one year from the date signed below. I understand that I can request, in writing, that the authorization be cancelled at any time. I do not authorize re-release of this information to anyone. A copy of the authorization is as valid as the original. I understand that once the Center for Pain Management has disclosed the health care information I have authorized, The Center for Pain Management has no control over the information and that this information may no longer be protected by privacy laws. The Center for Pain Management will not condition treatment for any patient that refuses to sign an authorization for release of Protected Health Information.			
Authorization: ** PLEASE SIGN	**I AUTHORIZE the above PROVIDER to release the INFORMATION designated to the REQUESTOR.**			
	Patient/Guardian Signature **		Date	
	Relationship to the Patient	Reason Patient Unable to Sign		

PLEASE NOTE: Information in the chart that was <u>not</u> generated by The Center for Pain Management will not be released to another facility. We recommend that the original facility be contacted to obtain those records.
** IF you are the legal responsible party acting on behalf of the patient, please provide legal documentation.