SEATTLE PAIN RELIEF
INTERVENTIONAL PAIN MEDICINE
35002 Pacific Highway South Suite A-105
Federal Way WA 98003

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Patient Name: _____ **DOB:** _____

I HEREBY AUTHORIZE:

_____ _____

_____ _____

TO RELEASE THE FOLLOWING INFORMATION:
□ The most recent 2 years of pertinent information (chart notes, lab reports, imaging and special tests)
□ All medical records
□ Specific Information:

DESIGNATED INFORMATION IS TO BE:
Fax: (253) 397-3207
Email: medicalrecords@seattlepainrelief.com

INFORMATION RELEASED TO:

Seattle Pain Relief – 35002 Pacific Highway South Suite A105 – Federal Way WA 98003

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. This authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse, and mental health conditions.

MY RIGHTS:
Seattle Pain Relief is hereby released from all legal responsibility or liability for the release of information designated above. I understand that I have the right to withdraw this authorization at any time and that such revocation must be done in writing. I also understand that this authorization, without prior, revocation, will expire 90 days from the date of signature.

Patient Signature Date

Relationship of status if signed by any other than patient (parent, legal, guardian, etc.)