INTERVENTIONAL PAIN & SPINE CARE, LLC
3280 Urbana Pike, Suite 207
Ijamsville, MD 21754

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____ Date of Birth:_____________________

SSN: ___________________ STREET ADDRESS:____

CITY/STATE/ZIP:____

PHONE #:______________________________ EMAIL ADDRESS:____________________________________

MEDICAL RECORD TO BE RELEASED:

FROM / TO (circle one)

Name (or title) and organization ____

Address ____

City _____________________________ State ____________________ Zip _____________________

Phone _______________________ Fax _________________________ Email _____________________

RECORDS FOR DATES: _________ to __________

____ All of my health information

___ Office Notes

___ Physical Therapy

___ Surgery Notes

___ Lab Report/Imaging Studies

___ Other: _____________________________

The purpose of this authorization is (check all that apply):

__ At my request ___Insurance ___Legal _____Other: _____________

This authorization ends:

☐ - On (date)___________________

☐ - When the following event occurs: ____

Patient/Parent/Guardian Signature: ___________________________________ **Date**: __________________