Sweetwater Pain & Spine

343 Elm St, Suite 202, Reno, NV 89503 | Phone (775)870-1480 | Fax (877)764-6351

CONSENT TO RELEASE/RECEIVE MEDICAL RECORDS

I, _____ ___/___/___ give permission to Sweetwater Pain & Spine to:

Patient Name Date of Birth

☐ **Receive** my medical history/records from the following physician(s):

Name_____ Phone_____

Address_____ Fax_____

☐ **Release** my treatment information/records to the following healthcare professional(s):

Name_____ Phone_____

Address_____ Fax_____

Information to be included:

☐Lab Reports ☐Imaging Reports (MRI,X-Ray, CT, Etc.)

☐Office Visit Notes ☐History & Physicals

☐Operative Reports ☐Procedure Reports

☐Other_____

This permission is given on a one time basis.

I hereby release the above-names facility or doctor(s) from all legal liability that may arise from the release of this information. I acknowledge that records to be released may include material that is protected by Federal Regulation 42 CFR, Part 2, including AIDS/AISDS Testing information, drug/alcohol information, and mental health information. My records are protected and cannot be disclosed without my written permission. I may make a request in writing at any time to this facility to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CR § 164.524. My signature below authorizes the release of all requested information. Such authorization may be revoked in writing at any time. Disclosed information may be subject to redisclosure by the recipient

_____ _____

Signature of Patient Requesting Records Date

_____

Printed Patient Name