REQUEST FOR COPIES OF MEDICAL RECORDS

NAME of Patient (Last, First, MI)**:** ___________________________

DOB (MM/DD/YYYY): _____________________________________

I, __________________________, request that the copies of my medical records from my treatment with Dr. Daniel E. Batlan at Specialized Pain Management [SPM] be sent. I understand and accept that these records will be sent by regular United States mail or by facsimile, and that SPM [and all individuals associated with SPM] are **NOT** responsible and/or liable in the event of lost or stolen medical records, and/or in the event that confidential information is received by individuals for whom this information is not intended.

I, __________________________, also understand that the copies I request I will be charged a standard fee – currently recognized as $0.60 [*sixty cents*] for each page. I also understand that after a written receipt of a request for medical records, SPM shall have ten [*10*] business days available prior to transmission of the requested medical records.

____
NAME

____
SIGNATURE

____
DATE

SPECIALIZED PAIN MANAGEMENT
DANIEL E. BATLAN, MD
Medical Director
1930 Village Center Circle #3-710 Las Vegas, NV 89134
TELEPHONE: 702.838.8004 FAX: 702.838.5085