SPECIALIZED PAIN MANAGEMENT

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information [*PLEASE PRINT*]

Name: _____ Date of Birth (*MM/DD/YYYY*): _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

What information is being requested? (*Mark ALL that apply*)

Date(s) of Service: _____

- ☐ Demographics/Facesheets
- ☐ Discharge Summary
- ☐ Consult/Office Notes
- ☐ Procedure Reports
- ☐ Lab Results
- ☐ Billing / Medical Charges
- ☐ **ALL** Health Information

Release Medical Records FROM:

☐ **Specialized Pain Management**, Dr. Daniel Batlan
1930 Village Center Cir, #3-710
Las Vegas, NV 89134
Ph# 702-838-8004 / Fax# 702-838-5085

☐ Facility/Physician Name, Address, Fax#:
_____
_____
_____
_____

Release Medical Records TO:

☐ **Specialized Pain Management**, Dr. Daniel Batlan
1930 Village Center Cir, #3-710
Las Vegas, NV 89134
Ph# 702-838-8004 / Fax# 702-838-5085

☐ Facility/Physician Name, Address, Fax#:
_____
_____
_____
_____

I understand and accept that these records will be sent by regular United States mail or by facsimile. Also, I understand that SPM [*and all individuals associated with SPM*] are ***NOT*** responsible and/or liable for any lost or stolen medical records… or in the event that the confidential information is received by individuals for whom this information is not intended for.

Lastly, I understand that the copies requested will be charged a standard fee of $0.60 [sixty cents] per page.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____