SPACE COAST PAIN INSTITUTE

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MEDICAL RECORDS REQUEST

I, _____DOB:_____
Give Space Coast Pain Institute permission to :

Please check one:

_____: Release a copy of my medical records to… _____
_____
_____: Request a copy of my medical records from … _____
_____

YOU NEED TO PROVIDE A FAX AND PHONE NUMBER!!!

_____

The following medical records (Please check all that apply):

_____ Office Notes _____ Procedure Notes

_____ Lab Results _____ MRI/X-ray Reports

_____ Physical Therapy Notes

I am requesting a copy for the following purpose (Please check all that apply):

_____ Insurance Company, Auto/Health Insurance (Please circle)

_____ Another Physician, Please give name:_____

_____ My Attorney, Please give name: _____

_____ Personal use: (A fee of $1.00 per page, up to $25.00 total)

I understand that the information in my record may include sensitive information about behavioral or mental health service, treatment for alcohol and/or drug abuse. It may also contain information related to sexually transmitted disease, Acquired Immuno-Deficiency Syndrome (AIDS), and infection with Human Immunodeficiency Virus (HIV). I understand that any disclosure of this information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

_____

Signature of Patient: Date: