

# Authorization for Release of Medical Records

*A clear, written record of who may share your health information, with whom,  
and for what purpose.*

## i. PATIENT INFORMATION

LAST NAME

FIRST NAME

MIDDLE

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DATE OF BIRTH

LAST 4 OF SSN

PHONE

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ADDRESS

CITY, STATE, ZIP

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## ii. DIRECTION OF AUTHORIZATION

I authorize Frontier Pain Relief to:

- Release** my medical records **to** the party named below
- Obtain** my medical records **from** the party named below
- Both** — exchange records with the party named below

## iii. OTHER PARTY INFORMATION

NAME OF PROVIDER, FACILITY, OR ORGANIZATION

PHONE

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ADDRESS

CITY, STATE, ZIP

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## iv. RECORDS TO INCLUDE \_\_\_\_\_

- Complete medical record    Office / progress notes    Imaging studies and reports  
 Laboratory results    Billing and account records    Other (specify below)

If "Other," please specify which records:

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## v. PURPOSE OF DISCLOSURE \_\_\_\_\_

- Continuing care    Second opinion    Personal use    Legal matter    Other

If "Other," please describe the purpose:

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## vi. EXPIRATION OF THIS AUTHORIZATION \_\_\_\_\_

This authorization will remain in effect **until I revoke it in writing**. To revoke, I must submit a written request to Frontier Pain Relief. Revocation will not apply to information that has already been released in reliance on this authorization.

## vii. SENSITIVE INFORMATION \_\_\_\_\_

I understand that my medical records may contain information about sensitive conditions, and I authorize the release of such information as part of this request unless I write specific exclusions below. **Records protected under federal law — including 42 CFR Part 2 substance use treatment, HIV/AIDS testing, mental health, and genetic information — require separate written authorization on a category-specific form and are not covered by this general authorization.**

Specific information I do **not** wish to be released (optional):

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viii. YOUR RIGHTS AND ACKNOWLEDGMENTS

**Right to Revoke.** I may revoke this authorization at any time by submitting a written request to Frontier Pain Relief. Revocation will not affect any information that has already been disclosed in reliance on this authorization.

**Conditions of Treatment.** Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, except as permitted by law.

**Redisclosure.** I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy regulations.

**Copy of Authorization.** I understand that I am entitled to a copy of this signed authorization upon request.

**Right to Inspect.** I understand that I have the right to inspect or receive a copy of any records released under this authorization.

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ix. SIGNATURE

By signing below, I certify that I have read and understood this authorization, and I authorize the release and/or receipt of medical records as described in this form.

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE

DATE

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PRINTED NAME OF PERSONAL REPRESENTATIVE  
(IF APPLICABLE)

RELATIONSHIP OR AUTHORITY TO ACT

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