



## **MEDICAL RECORDS RELEASE**

The following pages are forms necessary to authorize the release of medical records.

### **PLEASE NOTE**

One form authorizes the release of records FROM Georgia Pain and Spine Care to another organization, while the other form authorizes the release of records from another organization TO Georgia Pain and Spine Care.

Please fill out the appropriate form completely and fax or deliver it to our office.

*If you have any questions, please call our office*

### **GEORGIA PAIN AND SPINE CARE**

1665 Hwy 34 East, Suite 100

Newnan, GA 30265

T (770) 252-7557

F (770) 252-7513

[www.gapaincare.com](http://www.gapaincare.com)



## **AUTHORIZATION TO RELEASE MEDICAL RECORDS**

**FROM GEORGIA PAIN AND SPINE CARE**

I, \_\_\_\_\_ authorize Georgia Pain and Spine Care to release my medical records to the following person or organization:

Mail or Fax Records to: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Fax to Attn: \_\_\_\_\_

*Please note: All Faxes must be sent with HIPPA Fax Cover Sheet.*

I understand that this information will include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care and evaluations, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should not be released: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's Acct #: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

*This form is valid for one year from patient signature date.*



## **AUTHORIZATION TO RELEASE MEDICAL RECORDS**

**TO GEORGIA PAIN AND SPINE CARE**

I, \_\_\_\_\_ authorize the following  
person or organization, \_\_\_\_\_  
to mail or fax my medical records to:

**GEORGIA PAIN AND SPINE CARE** Attn: \_\_\_\_\_  
**1665 Highway 34 East, Suite 100**  
**Newnan, Georgia 30265**  
**Phone: (770) 252-7557 Fax: (770) 252-7513**

I understand that this information will include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care and evaluations, treatment for alcohol and/ or drug abuse, or similar conditions.

The following information should not be released: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's Acct #: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

*This form is valid for one year from patient signature date.*