FABITO ANESTHESIA & PAIN SPECIALISTS PC

Break the Wave of Pain

AUTHORIZATION FOR REALEASE OF RECORDS

I _____, do hereby request and authorize the office of FABITO ANESTHESIA AND PAIN SPECIALISTS to send or release my medical records to:

RECIPIENT: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

I UNDERSTAND THAT I HAVE THE RIGHT TO LIMIT THE TYPE OF DOCUMENT(S) RELEASED. UNLESS OTHERWISE INCICATED BELOW, MY SIGNATURE AUTHORIZES THE RELEASE OF ALL MEDICAL RECORDS WITHOUT EXCEPTION. THIS INCLUDES ANY INFORMATION CONCERNING HIV TESTING, PSYCHOLOGICAL, AND/OR PSYCHIATRIC TREATMENT, AS WELL AS ALCOHOL OR DRUG ABUSE.

_____

I UNDERSTAND THAT MY PERSONAL HEALTH INFORMATION IS PROTECTED BY HIPPA POLICIES AND PROCEDURES.

PRINTED NAME: _____ DOB:_____

SIGANTURE: _____ DOS:_____