



Expert Pain Physicians
Pain & Spine Wellness Center

Nitin Malhotra, MD
Neil Malhotra, MD

Interventional Pain Specialists
Fellowship Trained
Board Certified
expertpainmd.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: _____

Patient SSN: _____

Date of Birth: _____

To be completed by Office Staff only:

PATIENT AUTHORIZES RELEASE OF MEDICAL INFORMATION FROM:

Physician or Agency: _____

Street Address: _____

City, State, Zip: _____

Phone: _____

Fax Number: _____

| | | |
|------------|---|--|
| TO: | Expert Pain Physicians 16045 S. 108th Avenue, Suite C Orland Park, IL 60467 | Phone: 708-981-3901 Fax: 708-981-3912 |
|------------|---|--|

Patient authorizes the following information to be released*:

- | | |
|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Laboratory/Pathology Records | <input type="checkbox"/> Abstract/Summary |
| <input type="checkbox"/> Imaging Studies | <input type="checkbox"/> Other: _____ |

* Note: If these records contain any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are here by authorizing disclosure of this information.

I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time by my written statement. A signed copy or facsimile of this authorization for release of medical information may submitted as if it were an original certify that this authorization has been made voluntarily and shall remain valid for one year from the date set forth below unless I revoke my authorization by written notice to Expert Pain Physicians.

X

Patient Signature (or patient representative)

Date

Printed Name of Patient (or patient representative)

Representative's relationship to patient