Arundel Pain Associates

1406B South Crain Highway Suite 208
Glen Burnie, MD 21061
(P) 443-410-3309/ (Fax) 443-410-3326

Authorization for release of Health Information

Patient Name: _____
(Last) (First) (Middle Initial)

Address: _____

_____
(City) (State) (zip code)

DOB: _____ Phone# _____

I hereby Authorize the release of my Medical Records (labs, Imaging, pharmacy, H&P, Clinical) to be released to Arundel Pain Associates.

- I request a copy of my health information
- I authorize the Arundel Pain Associates, LLC to discuss my health information with the person or entity identified below, if that person contacts the Arundel Pain Associates, LLC.
- I authorize the Arundel Pain Associates to provide a copy of my health information to the person or entity identified below.

Name or other person/entity: _____

_____
(address) (city)

_____
(State) (Zipcode) (fax Number)

_____
Print Name of Patient Date:

_____
Signature of patient or guardian