Authorization to Release Medical Records

☐ I hereby authorize Virtuous Pain Centers to **RECEIVE** medical records from the provider listed below.

☐ I hereby authorize Virtuous Pain Center to **SEND** medical records to the provider listed below.

☐ I hereby authorize Virtuous Pain Centers to release records to **MYSELF**.

Facility/Physicians Name: ____

Phone #: ___________________________ **Fax #:** _____________________________

☐ VPC – Chandler
5505 W Chandler Blvd, Ste 11
Chandler, AZ 85226
P: 480.659.2571
F: 480.207.2713

☐ VPC – Mesa
5432 E Southern Ave, Ste 106
Mesa, Arizona 85206
P/F: 480.576.8177

☐ VPC – Flagstaff
823 N San Francisco St, Ste A
Flagstaff, AZ 86001
P/F: 520.244.0089

☐ VPC – Show Low
3401 S White Mountain Rd, Ste A
Show Low, AZ 85901
P/F: 928.537.7111

The request and authorization applies to:

☐ All pertinent medical records from _________________ to ____________________
☐ Imaging Reports
☐ Medication List
☐ Other ____

By signing, I understand that the health information authorized to be disclosed may include, but is not limited to information regarding drug abuse, alcohol abuse, psychiatric illness, records or testing, diagnosis or treatment HIV or HIV-related diseases, and communicable disease-related information. I understand that I may revoke this authorization at any time, with written consent, unless this authorization has already been acted upon. The authorization will expire in one year unless otherwise noted or requested. I have read this authorization and acknowledge that I fully understand its terms and conditions.

Patient Name: ____ DOB: __________________

Patient Signature: _____________________________________ Date: __________________