Pain Treatment Center Anesthesiologists, PC
600 N 9th St, Suite 2
Bismarck ND 58501
PH: 701-223-7822 FAX: 701-223-7844

Patient _____ Date of Birth_____

Address_____

Phone/Cell Number_____

PLEASE RELEASE MY MEDICAL RECORDS TO:

Physician, Facility or Self: _____
Address: _____
City, State & Zip: _____
Phone Number: _____
Fax Number: _____

OBTAIN MY MEDICAL RECORDS FROM:

Physician, Facility or Self: _____
Address: _____
City, State & Zip: _____
Phone Number: _____
Fax Number: _____

RECORDS TO BE RELEASED: ALL OR SPECIFY: _____

Reason for Release:

_____Specialist Appointment (specify date) _____ Insurance Company or Disability Claim_____

_____Attorney/Legal

_____Leaving practice (please specify reason) _____

_____Other (Please specify reason) _____

_____Request to access, inspect, or obtain a copy _ _____
of my medical record (please specify) _____

Re-disclosure: I understand that the information used and/or disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law.

Expiration: This Authorization will expire in 60 days.

Revocation: I understand that I may revoke this authorization at any time by notifying PTCA in writing by sending a letter to 600 N 9th St, Ste 2, Bismarck ND 58501. I understand that if I revoke this authorization it will not affect any actions that PTCA took before it received my revocation letter. For example, PTCA cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

This authorization is binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in the PTCA Privacy Practices.

Signature of Patient or Patient Representative : _____

Print Name of Patient or Patient Representative: _____

Date:_____