Denver Back Pain Specialists, LLC
7730 E Belleview Ave, Suite A-200
Greenwood Village, CO 80111
Phone: 303-327-5511
Fax: 303-327-5512

MEDICAL RECORD & X-RAY RELEASE

PATIENT INFORMATION

_____
Name

_____
Social Security #

_____
Birth Date

RELEASE INFORMATION TO or FROM
(Please circle one)

_____
Name

_____
Address

_____
City/State/Zip

GENERAL AUTHORIZATION: I hereby request and authorize Denver Back Pain Specialists, LLC to release/receive my medical records and/or x-ray studies to the above named. I understand that once Denver Back Pain Specialists, LLC discloses individually identifiable information pursuant to this Authorization, such information may no longer be protected under federal law, and may be further disclosed without my consent.

I understand that this Authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the Administrator at Denver Back Pain Specialists, LLC; however, the revocation will not have any effect on any actions Denver Back Pain Specialists, LLC took prior to receiving the revocation. I release Denver Back Pain Specialists, LLC and its physicians, physical therapists and staff from any and all liability concerning disclosure of this information.

SPECIFIC AUTHORIZATION: ( ) Please initial. Specifically authorize the release of the following information:

_____ Alcohol and/or drug abuse, if any

_____ HIV/Aids status, if any

_____ Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

_____ Copy of office visits

_____ Copy of hospital History & Physical, Discharge Summary, Operative Notes

_____ Copy of complete chart

_____ Copy of imaging studies

_____ Other: (specify) _____

This Authorization will expire on _____(indicate a date or event relating to you personally or to the purpose of the Authorization)

A copy/fax of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Signature of Patient/Legally Authorized Person Date

_____ _____
Printed Name of Person Authorized to Sign for Patient How Authorized

---

FOR PICK-UP OF MEDICAL RECORDS:

_____
Name of person authorized to pick up records for patient (PLEASE PRINT)

I, _____, authorize the above named person to pick up my medical records.

_____Photo I.D Checked Records released by:_____Date:_____