Nocio
Interventional Pain Management

Tel: (480) 818-4314
Fax: (602) 865-8171

Authorization For Release Of Records From Nocio

I, _____, authorize Nocio Interventional Pain Management, 4400 N Scottsdale Rd, Suite 805, Scottsdale, AZ 85251, Fax: 602-865-8171, Phone: 480-818-4314 to provide the following persons or entities with a complete copy of my confidential medical records:

Name: _____

Address: _____

_____

Fax: _____

Phone: _____

In addition to the general authorization to release records to the persons or entities listed above, I authorize the release of the records described as the following:

Communicable disease-related information, including records of testing, diagnosis, or treatment for HIV, HIV-related illness, AIDS, AIDS-related diseases.
Drug and alcohol treatment.
Psychological/psychiatric information, including diagnosis and treatment.
Pathology slides, x-rays, MRI, CT, other imaging, videotapes, photographs.
Laboratory examination results
Genetic screening.

Disclosure of this information is necessary for the provision of optimal interventional pain management care.

This authorization is valid for twelve (12) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released.

_____

Patient Date

_____

Legally Authorized Representative Relationship to Patient Date

_____

Witness Date