# Pine Tree Alternative Pain Clinic

## Medical Release

PATIENT NAME _____DOB _____

ADDRESS _____

PHONE _____ SSN _____

EMAIL _____

PROVIDER _____

PROVIDER PHONE _____ FAX _____

DIAGNOSIS/CONDITION(S) _____

_____

Please fax the following medical records as they relate to the above diagnosis:

| |
|---|
| *Progress notes **pertaining to diagnosis/condition** |
| *Summary sheet/problem list/ current medication list |
| *Any documented radiology or other reports diagnosis related |

**FAX TO: 207.990.2362 ATTN: TERRIE or KIM**

I hereby authorize the release of my medical records including records relating to mental healthcare, communicable diseases, HIV/AIDS, and treatment of alcohol and/or drug abuse to Pine Tree Alternative Pain Clinic. I do not wish to review these records. I understand my authorization will expire one year from the date of this request. By signing below, I understand that I may revoke this authorization in writing at any time. I also authorize any and all information needed for the continuity of care between Pine Tree Alternative Pain Clinic and my providers. I acknowledge that a HIPAA Privacy Notice is available upon request.

_____

**Patient Signature** **Date**