EXODUS PAIN CLINIC
INTERVENTIONAL SPINE & PAIN MEDICINE

8950 W Emerald St. Ste. 168
Boise, ID 83704
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INFORMATION & RECORDS RELEASE

PATIENT NAME: _____ DOB :_____

ADDRESS: _____PHONE:_____

(Please circle one)

TO or FROM: EXODUS PAIN CLINIC

TO or FROM: _____

_____

_____

_____

Information to be released:

____ chart notes ____ imaging ____ lab reports ____ all records

____ surgical reports ____ other: _____

This information is to be used for the following purpose: _____

I hereby consent to release the above state information. I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give specific authorization for these records to be released. This information may be used by the person I authorize to receive it for medical treatment, consultation, billing or claims. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: _____ Date: _____

Relationship to the patient: _____