Patient Medical Records Request & HIPAA Authorization Form

Please complete the form below to request that your medical records be released to a provider of your choice or to NorCal Pain Treatment Center. This form is HIPAA-compliant and ensures your privacy is protected.

Patient Information

Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Email Address: _____

Address: _____

Records Release Request

☐ I authorize my records to be sent to:

- ☐ NorCal Pain Treatment Center
- ☐ Other provider/facility (please complete below):

Receiving Provider/Facility Name: _____

Contact Person (if known): _____

Phone Number: _____

Fax Number: _____

Address: _____

Email (if accepted): _____

Information to be Released

☐ Complete Medical Records ☐ Imaging Reports

☐ Procedure Notes ☐ Other (please specify):

Purpose of Disclosure

☐ Continuation of Care ☐ Personal Use

☐ Legal ☐ Other (specify):

Authorization

By signing below, I authorize Central Valley Pain Management to release my protected health information as indicated above. I understand:

- This authorization is voluntary and I may revoke it at any time by submitting a written request.
- Revocation will not affect disclosures made before the revocation was received.
- I understand that once my information is released, it may no longer be protected by HIPAA if disclosed to a non-covered entity.
- This authorization expires one year from the date signed unless otherwise specified below.

Expiration Date of Authorization (optional): _____

Signature & Date

Patient Signature (or Legal Representative):

_____

Date: _____

If signed by a Legal Representative, print name and relationship:

Name: _____

Relationship: _____

Submit Options

You may download, complete, and submit this form via email OR print and return it to our office by:

Email: brenna@cvpm.net

Mail to: 1300 Mable Ave. Suite #2, Modesto, CA 95355