NEVADA ADVANCED PAIN SPECIALISTS
CENTER FOR INJURY REHABILITATION

Denis G. Patterson, DO
Board Certified Pain Medicine
Board Certified Physical Medicine & Rehabilitation

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name	Contact Number	Date of Birth

Authorizes:

_____
Name of Healthcare Provider/Plan/Other

_____
Address

_____
Phone/ Fax

Release To:

Nevada Advanced Pain Specialists
Name of Healthcare Provider/ Plan/ Other

5578 Longley Lane, Reno, NV 89511
Address

775-284-8650 775-284-8654
Phone/ Fax

Information to be released:

__entire record	__physical therapy	__billing
__progress note	__lab results	__other:_____
__procedure notes	__imaging	

Dates of service: _____ to _____

Reason for Disclosure:_____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. . A copy, electronic copy, image, or facsimile of this authorization is as valid as the original.

I understand that the person(s) and/or organization(s) above that I am authorizing to use/disclose my information may not condition my treatment, payment, or eligibility for healthcare benefits on my decision to sign this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

This authorization is valid for 12 months following the date of my signature shown below.

_____ _____
Signature of Patient or Representative Date

_____
Relationship to Recipient