NEVADA ADVANCED PAIN SPECIALISTS
CENTER FOR INJURY REHABILITATION

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Date of Request: _____

Release Records From:

Nevada Advanced Pain Specialists
10715 Double R Blvd, Suite 101
Reno, NV 89521
P (775) 284-8650
F (775) 284-8654

I _____& ___/___/___, hereby consent to and authorize you to **release to:**
Patients Name DOB

_____ Phone (_____) _____-_____

_____ Fax (_____)_____-_____

_____

Pertaining to the healthcare services that were provided to: _____ (name of patient)

Specified Records:_____

_____

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.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation; this authorization shall remain in full force and effect and shall not otherwise expire.

Date _____ Signature of Recipient: _____

OR signature of parent or representative: _____

Relationship to Recipient: _____