CONSULTANTS IN PAIN MEDICINE, P.A.

PH: 210-546-1470
FX: 210-546-1479
www.cipm.com

Mark A. Moran, M.D., M.S.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Social Security #: _____

I hereby authorize the release of my medical records to:

Consultants in Pain Medicine, P.A.
Dr. MARK A. MORAN, M.D., M.S.
Fax: 210-546-1479

Requesting medical records from: (please enter complete address)

DR _____

ATTN: MEDICAL RELEASE DEPARTMENT

PH: _____

FX:_____

Please Check All That Apply:

☑ Labs
☑ X-Rays, CTs, MRIs --CURRENT
☑ Last 3 Progress Notes
☐ All Medical Records
☑ Other: MEDICATION LIST AND LABS

Patient Signature: _____ **Date: _____**

This authorization will automatically expire two (2) years from the date signed.

*In order to comply with regulation for Health Insurance Portability and Accountability Act (HIPAA) governing the confidentiality of patient information, a fully completed, HIPAA compliant, Authorization to Release Medical Records must accompany each request for medical records even though you may have already obtained a signed consent from the patient.

We are sorry for any inconvenience this may cause, but the laws were enacted to protect the confidentiality of medical information. Physician must comply with HIPAA privacy standards by requiring a fully completed form with all required information before releasing patient information. **Thank you for your cooperation**