Regenexx® PITTSBURGH

RAPS Medical (www.regenexxpittsburgh.com)
107 Gamma Drive, Suite 220, Pittsburgh, PA 15238
Ph: 412-963-6480 Fax: 412-963-6820

Authorization for Release of Protected Health Information

Patient name: _____

Date of Birth: _____

Address: _____

- I, _____ hereby authorize RAPS to release the following information or copies of:

  ___lab results ___radiology results (xray ,CT, MRI, etc…) ___hospital documents

  ___Entire medical record including above information ___Billing

  ___other (specify)_____

  Reason for request: ___continuing treatment ___legal ___second opinion

  ___employer ___other ___I do not wish to disclose the reason

  Release to: _____

  _____

  _____

- I, _____, give my permission for RAPS to obtain my medical records to assist them in the evaluation and treatment of my pain condition.
  Treatment dates_____

  Test results_____

  Please contact our office should you have any questions

PLEASE FAX RECORDS TO OUR OFFICE AT 412-963-6820

I understand RAPS has legally protected health information about me. I understand that signing or not signing this form will not affect the treatment I receive. I understand this authorization will expire in six months from date signed unless I revoke the authorization in writing. I understand that recipients may redisclose information which I have authorized them to receive.

_____ _____

Patient signature date witness date