

AUTHORIZATION FOR RELEASE OF INFORMATION**SECTION A****Release of Medical Records to Injury Specialists**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. ***Injury Specialists does not release secondary (patient records sent to Injury Specialists for review) patient records.***

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Persons/Organizations providing the information:

Persons/Organizations receiving the information:

**Gateway Pain Center, DBA Injury Specialist
10435 Clayton Rd.
Suite 120
St. Louis, MO 63131
314-985-3002
Fax 314-985-3012**

SECTION B**Please Read Carefully:**

I understand that this authorization will expire one year from the date below.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except the extent the organization has taken action in reliance on the consent.

Patient Signature_____
Date_____
Parent/Guardian Signature
(if patient is a minor)_____
Date***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION***