ELPIS PAIN MANAGEMENT CENTER

Medical Information Release Form

1. I, _____, authorize _____
(Patient's Name) (Provider's Name)

to release records to:

Elpis Pain Management Center
Dr. Vivek Manchanda MD.
4122 Keaton Crossing Blvd. Suite 102
O'Fallon, MO 63368
P 636-329-9077 F 636-329-9076

2. I request only the following information to be released/obtained:

☐ All medical records ☐ Emergency Report ☐ Lab Report ☐ History and Physical

☐ Discharge Summary ☐ Radiology Reports (X-ray/MRI/CT/Ultrasound etc.)

☐ Operative Report ☐ Other (Specify) _____

3. Purpose of Disclosure: (Check applicable purpose)

☐ Payment of Insurance ☐ Continued Medical Care ☐ Other: _____

4. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

SPECIAL AUTHORIZATION:
By Initialing in each box below, I am authorizing the office to release any and all information regarding:

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ AIDS/HIV

☐ Sexually Transmitted Diseases ☐ Hep A/Hep B

Note: If this release pertains to alcohol, drugs, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Name: _____ SSN: _____-_____-_____ DOB:_____

Patient Signature:_____ Date:_____