ARIZONA
BACK PAIN INSTITUTE
Let us help you start a new day

Authorization to Release Medical Records

Patient Name: _____ Date of Birth: _____

_____I hereby authorize Arizona Back Pain Institute to RECEIVE medical records from the provider listed below.
_____I hereby authorize Arizona Back Pain Institute to SEND medical records to the provider listed below.
_____I hereby authorize Arizona Back Pain Institute to release records to myself.

Facility/Physicians Name: _____

Telephone#: _____ Fax#: _____

Wladislaw Fedoriw, MD
5505 W Chandler Blvd Suite #11, Chandler, AZ 85226
Phone: (480) 659-2571 Fax: (480) 207-2713

The request and authorization applies to:

- ☐ All pertinent medical records from _____ to _____
- ☐ Imaging reports
- ☐ Medication list
- ☐ Other _____

By signing, I understand that the health information authorized to be disclosed may include, but is not limited to information regarding drug abuse, alcohol abuse, psychiatric illness, records or testing, diagnosis or treatment for HIV or HIV-related diseases, and communicable disease-related information. I understand that I may revoke this authorization at any time, with written consent, unless this authorization has already been acted upon. This authorization will expire in one year unless otherwise noted or requested. I have read this authorization and acknowledge that I fully understand its terms and conditions.

Patient Signature: _____ Date: _____