REDDY & ASSOCIATES, P.C.
A Practice of Pain Management
7600 Central Ave
2nd Floor, Founders Building
Philadelphia, PA 19111

Phone: (215) 725-7600 Fax: (215) 725-770

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS/HEALTH INFORMATION

I, ______________________________________, hereby authorize Reddy &
(patient's name)

Associates to release or disclose the following information for treatment between

_______________________________:
(dates of service requested)

___Consultation report ____Treatment Notes ____Billing Records

Please print below the name and address of the person receiving the requested information:

Name_________________________________ DOB_____________________
Address____
City/State/Zip____
Phone____
Purpose of the
disclosure____

I understand that certain fees may apply for the release of these records and that this consent may be revoked at any time, except to the extent that disclosure has already occurred in reliance on this request. Otherwise, this authorization shall be valid for a period of ninety (90) days from the date of my signature.

Signature ____________________________________Date_________________
(patient or legal guardian)