Kikkeri International, Inc.
dba Advanced Pain Solutions

Dear ______________________________

Attached is a medical release form to request records from your physicians and any imaging you may have had done.

Please fill out this first page completely with the information for the doctors that we need to request records from. For the second page, please **ONLY** fill in your **name**, **date of birth**, **social security number**, and **sign and date at the bottom.**

Once completed, please return the forms to our office or via email, fax, or mail as soon as possible. If you have any questions please feel free to contact the office at the phone number below.

NAME OF DOCTOR: ____

SPECIALTY: ____

ADDRESS: ____

PHONE: ___________________________ **FAX:** ___________________________________

NAME OF DOCTOR: ____

SPECIALTY: ____

ADDRESS: ____

PHONE: ___________________________ **FAX:** ___________________________________

NAME OF DOCTOR: ____

SPECIALTY: ____

ADDRESS: ____

PHONE: ___________________________ **FAX:** ___________________________________

FACILITY(S) WHERE ANY IMAGING HAS BEEN DONE: ___________________
____
ADDRESS: ____
PHONE: ___________________________ **FAX:** ___________________________________

THANK YOU,
NEW PATIENT DEPARTMENT

ADVANCED PAIN SOLUTIONS
3865 CHILDRESS AVE, SUITE A
MESQUITE, TX 75150
PHONE: (972) 681-7246 FAX: (888) 366-8067

Kikkeri International, Inc.
dba Advanced Pain Solutions
AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: ______________________________ Date(s) of Service: ____All____

Patient Date of Birth: __________________________ Social Security Number: __________________

I, the undersigned, authorize the release of/or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

(✓) Continuing Medical Care ( ) Military (✓) Social Security/Disability

(✓) Insurance (✓) Personal Use (✓) Other: __________________

(✓) Legal Purposes (✓) School __________________________

INFORMATION TO BE RELEASED OR ACCESSED:

(✓) History & Physical (✓) Consultation Report (✓) Emergency Room Record

(✓) Operative Reports (✓) Discharge/Death Summary (✓) Face Sheet

(✓) Lab/Pathology Reports (✓) X-Ray Reports/Images (✓) External Prescription History

( ) Other: __________________

The above information may be released to:

Kikkeri International, Inc., dba Advanced Pain Solutions	(972) 681-7246		(972) 681-1079
(Doctor, Hospital, Attorney, Insurance, Self, etc.)	Phone		Fax
3865 Childress Ave., Suite A	Mesquite	TX	75150
Street Address	City	State	Zip Code

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used to disclose pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodefiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand that I may be charged a retrieval or processing fee for copies of my medical records according to Texas Hospital Licensing Law.

This authorization will expire upon discharge unless I revoke the authorization prior to that time or unless otherwise specified.

Patient/Guardian Signature: ____________________________________ Date: __________________

If guardian, relationship to patient: ____________________ Printed Name: __________________________