New Solutions Pain Management Clinic, LLC
240 Indian River Road
Orange, CT 06477
Phone: 475-882-6824 Fax: 203-693-2320

Authorization to Release/Disclose Protected Health Information

Patient Name:________________________________ ___________________________________
(Last) (First)

DOB: ________/_________/________ **Phone:**____________________________________

Current Address:____
(Street Name, Apt #)

____ _________________________
(City, State) (Zip Code)

I hereby authorize New Solutions Pain Management Clinic, LLC to

Release l Obtain

(Please circle one)

Information from my medical records from the individual listed below:

Provider's Name/Facility Name:____

Phone:__________________________________ **Fax:**___________________________________

This information is to be used for the purpose of (circle all relevant):

Self **Further Medical Care** **Attorney** **Other:**___________________________
(Please Specify)

Please specify what is to be released/obtained below (i.e: office notes, labs, imaging, etc)

____

If this request is not filled out in its entirety we will be unable to complete your request.

Please allow 5-7 business days to initiate the process, all requests will be processed within 30 days of receipt; we try our best to process all requests in a quick and timely manner.

____ _________________________
Signature of Individual **Date**