Paradigm Pain and Spine Consultants

Robert Klickovich, MD

(T) 859-282-2024/ (F) 859-282-6747

REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize: _____

_____

_____

To release photo static copies of ALL medical records complied during office visits and/or hospital admissions:

Patient: _____

DOB: __/__/____

SSN: ____-____-_____

Release medical records to: Paradigm Pain and Spine Consultants

7000 Dixie Highway

Florence, KY 41042

Purpose or need for information: To continue medical care/treatment.

This consent will expire in (90) days from date below or sooner at my election. I place no limitations on history of illness or diagnostic and therapeutic information.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Date: __/__/____ Signature: _____

ANY DISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT(S) IS PROHIBITED