



**JOHNSTON PAIN MANAGEMENT, P. A.**

250 Huff Drive – Jacksonville, NC 28546  
Phone: (910)353-4414 – Fax: (910)353-2972

**RECORDS RELEASE**

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION  
PLEASE ALLOW 7 TO 10 BUSINESS DAYS FOR YOUR REQUEST TO BE PROCESSED!**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Reason for Request: \_\_\_\_\_

Date(s) of service needed: From \_\_\_\_\_ To: \_\_\_\_\_

**I authorize Johnston Pain Management, P.A.:**

To release my medical records to:

To request my medical records from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Options:**

Pick up in office

Mail (United States Postal Service)

Fax to provider (Please provide fax number)

**Medical Record Copying Charge:**

The following charges apply to copying records requested for personal use, attorneys', insurance purposes, disability determination and various other reasons:

\$12.00 (1 to 25 pages)  
If records exceed 25 pages it will be the initial \$12.00 fee plus  
\$0.50 per page (26-100 pages)  
\$0.25 per page (101 and up)

I understand that I have the right to revoke this authorization, in writing at any time except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that I uses and disclosures already made based upon my original permission cannot be withdrawn. To revoke this authorization I must do so in writing and send it to Johnston Pain Management.

\_\_\_\_\_  
**Signature:**

\_\_\_\_\_  
**Date:**

Expiration date is one year from date signed unless otherwise stated: \_\_\_\_\_

**For Office Use Only:** Date Records: Faxed / Sent / Picked Up: \_\_\_\_\_

Initials: \_\_\_\_\_