MILE HIGH REGENERATIVE AND PAIN THERAPY

12596 W. Bayaud Ave, suite 205, Lakewood CO 80228 | (p): 303-945-4790 | regeneration@mhrapt.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Patient: _____ Date of Birth: _____

I hereby authorize Mile High Regenerative and Pain Therapy to request patient information from:

Rocky Mountain Pain Solutions

The following information is to be released to Mile High Regenerative and Pain Therapy (fax #: 1-877-861-0393)

X Entire Record to include:
- XX: Visit Notes from first visit to present
- XX: All procedure notes
- XX: All imaging results from first visit to present
- XX: All lab results from first visit to present
- XX: All other provider and facility notes from first visit to present

This authorization is subject to my written cancellation at any time.

Patient Signature: _____ Date: _____