



Clary Document Management, Inc.  
4190 Vinewood Ln N  
Ste 111 #201  
Plymouth, MN 55442

Phone: 763.548.1320 | Fax: 763.548.1325 | chartcontrol@clarydm.com | www.clarydm.com

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_

I request all medical records of the patient named above to be released from:

Send all medical records to:  
same address as above **\$20**  
or  
other address below **\$20**

**Omega Pain Management**  
6348 Lonas Spring Drive  
Knoxville, TN 37909

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Year of Last Visit: \_\_\_\_\_

Reason for Release of Information:

Email: \_\_\_\_\_

Fax : \_\_\_\_\_

This request and authorization applies to all my medical records. I understand my medical records may include information regarding mental health, psychotherapy notes, alcohol/drug use, Sexually Transmitted Disease results (whether positive or negative) and HIV treatment. I understand this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when Clary Document Management (Clary) receives my notice in writing submitted to the address above. I understand once Clary discloses my health information herein, it may no longer be protected by federal privacy laws.

**I understand I will *pre-pay* a \$20 fee to reproduce medical records.**

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient Authorized Representative: \_\_\_\_\_

Date \_\_\_\_\_

Authority to Represent Patient: \_\_\_\_\_