Comprehensive Pain Management
Authorization to Release Medical Records

I _____ who resides at _____ in the city of

_____ in the state of _____ herby authorize:

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

Fax: _____

To disclose the following specific medical information by mail or fax to:

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

Fax: _____

From the Health Records of:

Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

For the purpose of: _____

My authorization extends only to those checked below:

_____ Billing Information
_____ Record of Visits: All or Specific Dates: _____ to _____
_____ Progress Notes
_____ Operative Notes
_____ History and Physical
_____ Consults
_____ Lab Reports
_____ MRI Films/Reports

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time except where information has already been released. This authorization is valid for a one year period from the date that it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
4. Comprehensive Pain Management Center, its employees, officers, and physicians are hereby released from any legal responsibility or liability for discloser of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used to disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

Patients Name Date

_____ _____

Patients Signature Expiration Date

_____

Patients Social Security Number

_____ _____

Patients Personal Representative Date

_____

Patients Personal Representative's Authority to Act

_____

Witness