

Comprehensive Pain Management Authorization to Release Medical Records

I _____ who resides at _____ in the city of _____ in the state of _____ hereby 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

