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	on 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 be	low:
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.
- 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 Aut	hority to Act
Witness	