

Comprehensive Pain Specialists

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Release of Medical Records

Patient's Address: \_\_\_\_\_

Patient's Telephone Number: \_\_\_\_\_

Last 4 digits of SS# \_\_\_\_\_

Please "Print" and complete all sections to insure your request is processed in a timely manner

MAIL RECORDS TO: \_\_\_\_\_
Include full address \_\_\_\_\_
and phone number \_\_\_\_\_

Items needed-Circle all that applies: Last 3 Office Notes, Labs, Billing, Discharge letter or ALL

PURPOSE OF DISCLOSURE: \_\_\_\_\_

I authorize Comprehensive Pain Specialists to release or disclose to the above-named entity all of my medical records as specified above, including any specially protected records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle-cell anemia, or HIV infection for the purpose of medical treatment.

If you Do Not Want certain portions of your medical records released, please read this section carefully and identify the information you do not want released. Otherwise, your records will be released as specified above.

This Authorization will expire a year from date of signature.

\*\*\*\*Please initial: I authorize the release of past, present and future dates of service after date of signature: \_\_\_\_\_

\* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by Comprehensive Pain Specialists or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to Comprehensive Pain Specialists at the address shown below.

\* I understand that I am not required to sign this Authorization. Comprehensive Pain Specialists will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

\* I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit Comprehensive Pain Specialists' or its physicians', employees' or agents' ability to use or disclose my information for treatment, payment, or health care operations, or as otherwise permitted by law.

Patient or Authorized Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the patient if not signed by patient: \_\_\_\_\_ POA Provided? \_\_\_\_\_

Driver's license verified: \_\_\_\_\_ Scanned by (initials): \_\_\_\_\_