Comprehensive Pain Specialists

Patient Name: _____ **DOB:** _____

Medical Records Request

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

FAX RECORDS TO: _____

_____

PURPOSE OF DISCLOSURE: Continuity of Care

I authorize _____to release or disclose to the above-named entity all of my medical records, 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.

_____

* 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.
* I authorize CPS to request records pertinent to my treatment from providers and other healthcare entities, as needed, within the time this authorization is valid. This Authorization will expire a year from date of signature.

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):_____

The section below this line is to be completed by your CPS Provider_____

Records needed: ☐ CT of _____ ☐ MRI of _____ ☐ Operative Report _____

☐ Other _____ ☐ X-ray of _____ ☐ Discharge Letter ☐ Recent Progress Notes

CPS Corporate Phone: 615.442.3609 Fax: 888.295.1610