COMPREHENSIVE
PAIN MANAGEMENT
SPECIALISTS

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name
last_____ first_____ middle_____

primary phone_____ date of birth_____

THE UNDERSIGNED HEREBY AUTHORIZES

Records Release FROM:

☐ Comprehensive Pain Management Specialists

☐ Other _____

name_____

phone _____ fax _____

address _____

city/state/zip_____

Records Release TO:

☐ Comprehensive Pain Management Specialists

☐ Other _____

name_____

phone _____ fax _____

address _____

city/state/zip_____

Date of Treatment/Service:_____

PLEASE DISCLOSE/RELEASE THE FOLLOWING INFORMATION (check all that apply)

☐ Office notes including medication list
☐ X-Ray/Radiology Records (reports only, no images unless specified)
☐ Laboratory/Pathology Records
☐ Discharge Document(s)
☐ Behavioral/Mental Health Records
☐ Other (describe specifically): _____

I understand and acknowledge that the Medical Record may contain information regarding psychiatric disorders, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependency/abuse.

I understand that the information that I authorize a person or entity to receive may be re-disclosed and no longer protected by Federal Policy Regulations.

Patient Signature_____ **date**_____

Signature of Patient's Legal Representative_____ date_____

☐ Parent/Guardian ☐ POA ☐ Executor

CPMS Use Only:

Witness_____ date_____

☐ Records Given to Patient ☐ Payment Received for Records $_____

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