COMPREHENSIVE PAIN MANAGEMENT SPECIALISTS

P.O. Box 501724, San Diego, CA 92150
Telephone: 858.453.7700
Fax: 858.798.1225

Today's Date _____

I hereby authorize communication regarding my care, between Comprehensive Pain Management Specialists and the Person/Persons named below:

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

This consent may be revoked at any time by the undersigned by written notice except to the extent that action has already been taken or is required by law. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above. I understand that I am under no obligation to sign this authorization and that agreeing or declining to sign this form will not affect my treatment at Comprehensive Pain Management Specialists. I understand that Comprehensive Pain Management Specialists has no control over my information once it leaves their possession.

Patient Name (PRINT):_____ DOB: _____

Patient or Responsible Party's Signature:_____

Relation to Patient: _____ Date: _____

*Note: This release will expire one year from the date above. I understand that I have the right to limit the type of information released. If I choose to limit the information released, I understand that it may be necessary for Comprehensive Pain Management Specialists to inform the requestor that portions of the record have been withheld. Medical care providers also retain the right and responsibility to withhold releasing records that may be detrimental to the welfare of the patient.

Initials: _____