COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

P.O. Box 501724, San Diego, CA 92150-1724
Telephone: 858-453-7700
Fax: 858-798-1225

CPMS PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

I hereby grant permission to **COMPREHENSIVE PAIN MANAGEMENT SPECIALIST** to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug or alcohol records, which must be authorized on a separate release.

Name	DOB	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

You may discuss my (please check all that apply)

- ☐ Visit notes
- ☐ Laboratory Results
- ☐ Radiology Reports
- ☐ Reports
- ☐ All services and Treatments Rendered
- ☐ Other: _____

I understand that I may revoke this authorization at any time in writing.

_____ _____

Print Patient Name DOB

_____ _____

Patient/Guardian Signature Date