COMPREHENSIVE CENTERS
FOR PAIN MANAGEMENT

WEST CENTRAL SURGICAL CENTERS

☐ **CC4PM-SYLVANIA** ☐ **CC4PM-BAYSIDE** ☐ **CC4PM-ASPEN GROVE** ☐ **WCSC-CENTRAL**

PATIENT NAME:_____**DOB:**_____

CONSENT TO DISCLOSE MEDICAL INFORMATION

What type of message can we leave for you???

In an effort to better serve you, Comprehensive Centers for Pain Management needs to know what type of messages we can leave on your message machines/voicemail. Please indicate your preference for contacting you by phone.

CC4PM may leave a detailed message on my answering machine/voicemail:

YES _____ **NO** _____ **Other** _____
If no, we will leave enough information for you to call us back.

CC4PM will always leave detailed information when confirming your appointments, unless otherwise indicated by you, the patient.

AGREE _____ **DISAGREE** _____ **if you disagree, a message to call us back will be left on your answering machine/voicemail.**

Who can we speak to concerning your Protected Health Information???

Please tell us to whom we can disclose or discuss your Protected Health Information. Please check the types of information that you authorize CC4PM to disclose/discuss with indicated family/friends:

_____ **Relationship**_____

_____ **Relationship**_____

My Entire File_____ or specifically: (circle choices)

Diagnosis	Progress to Date	Dates of Treatment	Clinical Psychologist
Prognosis	Billing Information	Treatment Plan	Symptoms
Test Results	Modalities & Frequencies of Treatment Furnished		Other_____

I understand that I may revoke or change this authorization at anytime by completing another Consent to Disclose Medical Information form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that I have the right to receive a copy of this authorization, if requested. I understand that this authorization will not expire.

Signature: _____Date: _____