



COMPREHENSIVE CENTERS
FOR PAIN MANAGEMENT

William G. James, MD
Nadeem Moghal, MD
Alexander Escobar, MD
Matthew Rogers, PsyD

West Central Surgery Center- 7055 W. Central Avenue, Toledo, OH 43617
CC4PM- 3400 Meijer Drive, Toledo, OH 43617
Bayside- 846 S. Coy Road, Toledo, OH 43616
Phone: (419) 843-1370 Fax: (419) 843-1362

RECORDS RELEASE AUTHORIZATION

To release records to another medical facility

Date: _____

Name: _____

Date of Birth: _____

I hereby authorize Comprehensive Centers for Pain Management and West Central Surgical Center to release copies of any medical records in their possession, including the actual x-ray films concerning my illness and/or treatment period.

_____ Specific Dates (From): _____ (To): _____

_____ Entire Medical File (Standard two years of information, unless otherwise specified) ("All" is not an acceptable date range)

Please send to the following address:

Name: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Signature: _____

Print Name: _____

REASON FOR REQUEST FOR MEDICAL RECORDS

- | | |
|--------------------------------------|---|
| _____ Litigation/Attorney Request | _____ Going to Another Pain Management Provider |
| _____ Disability Request | _____ Leaving Area |
| _____ Another Provider | _____ Discharged From Practice |
| _____ Returning to PCP for Treatment | _____ Other: _____ |

- If this authorization is not completed in its entirety, it will be returned. This will result in the information not being released until the form is properly completed.
- There may be a charge for these records. Payment must be received before the records will be released.
- The Medical Records Department reserves the right to only send what they deem as medically necessary.
- Records will **ONLY** be released directly to the medical facility or patient, and not to friends, spouses, or family members.