COMPREHENSIVE CENTER FOR PAIN MANAGEMENT

and

WEST CENTRAL SURGICAL CENTER

(TO RELEASE RECORDS TO ANOTHER MEDICAL FACILITY)

William G. James, MD
Nadeem Moghal, MD
James A. Weiss, MD
James J. Otting, MD

MOHAMMAD S. HEFZY M.D.
BRYANT ITIARRA D.O.
JAMES BASSETT M.D.
SCOTT SHORT, M.D.

7053 West Central Ave.
Toledo, OH 43617
419-843-1370 Phone
419-843-1362 Fax

RECORDS RELEASE AUTHORIZATION

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 _____

☐ Entire Medical File

Please send to the following address:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____

Print Name:

REASON FOR REQUEST FOR MEDICAL RECORDS

☐ LITIGATION/ATTORNEY REQUEST

☐ DISABILITY REQUEST

☐ ANOTHER PROVIDER

☐ PT DISCHARGED

☐ GOING TO ANOTHER PM PROVIDER
☐ LEAVING AREA
☐ CUSTOMER SERVICE ISSUE
☐ DISCHARGED FROM PRACTICE
☐ RETURNING TO PCP FOR TREATMENT

STAFF TO COMPLETE

☐ Alert added to patient's account - Pt leaving practice as of _____
☐ Check accoun for appointments that need to be cancelled

FRONT OFFICE STAFF MUST COMPLETE FORM IN ITS ENTIRETY PRIOR TO SUBMITTING TO MRD

Please forward to the Medical Records Department for processing