COMPREHENSIVE CENTERS
FOR PAIN MANAGEMENT

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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:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Signature:_____

Print Name:_____

REASON FOR REQUEST FOR MEDICAL RECORDS

_____Litigation/Attorney Request
_____Disability Request
_____Another Provider
_____Returning to PCP for Treatment
____Going to Another Pain Management Provider
____Leaving Area
____Discharged From Practice
____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.