I hereby authorize **Comprehensive Pain Specialists** to release or obtain medical records and data pertaining to:

Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify what records should be: ***RELEASE*** ***OBTAIN***

❑ All my health information including, but not limited to, AIDS/HIV and other Communicable Disease information, Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug abuse Treatment, if any unless specifically excepted: ____.
❑ My health information relating to the following treatment or condition: __________________.
❑ All Psychotherapy notes unless specifically excepted: _________________________________.
❑ Other____.

Please specify method of release and to disclose this health information to:

❑ Pick-up ❑ Mail to: ❑ Fax to: ____________________________________

Name:	**Title/Business:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Relationship to Patient:**

❑ at my request
❑ other (specify) ____.
❑ Check here only when (physician or clinic) requests the authorization for marketing purposes.

This authorization ends:
❑ on (date) __________________.
❑ when the following event occurs____.

Patient/Guardian Signature: ___________________________________ Date: ___________

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