COMPREHENSIVE PAIN
MANAGEMENT SPECIALISTS

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Comprehensive Pain Management Specialists to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse		
Children		
Guardian		
Caregiver		
Sister		
Brother		
Friend		
Emergency Contact		
Other		

You may discuss my (please check all that apply)

☐ Visit Notes ☐ Laboratory Results ☐ X-rays ☐ Reports ☐ All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)_____ Patient Date of Birth_____

Patient/Guardian Signature_____ Date_____