Comprehensive Pain and Spine Specialists LLC
Specializing in Minimally Invasive Spine

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone: _____

Address: _____ Date of Birth: _____
MM / DD / YYYY

I authorize the custodian of records of: _____
to disclose/release the following information: (check all applicable) (Fees may be charged for processing this request.):

- ❑ All records
- ❑ Inpatient Medical Records
- ❑ Outpatient Medical Records
- ❑ X-Ray/Radiology Records
- ❑ Pharmacy/Prescription records
- ❑ Psychotherapy/Psychiatric Care Records [**Note:** If this authorization is for psychotherapy notes, it may not be combined with any other authorization (other than another authorization for

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

❑ Please send the records listed above to (use additional sheets if necessary):

Name: **Comprehensive Pain and Spine Specialists, LLC**
Address: **3570 N Briarwood Lane, Muncie, IN, 47304**
503 S Tillotson Ave, Muncie, IN, 47304
Phone Number: **765-224-6513**
Fax Number: **765-247-7619**

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient/Patient Representative Relationship to Patient if signed by representative

_____ _____
Printed Name of Patient Date