



Board Certified Pain & Rehabilitation Physicians

COMPREHENSIVE PAIN MANAGEMENT

www.azcpm.com

3811 E. Bell Rd., Suite 207 Phoenix, AZ 85032 Phone (602) 971-8200 Fax (602) 971-8201

James KellerShabrokh, D.O. • Steven Giacoppo, D.C., FNP • Shelby Schweitz, FNP-BC

CONSENT FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFO:

LAST NAME: _____ FIRST NAME: _____ DOB: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE NUMBER: _____

As the patient, Or The patient's legal representative, I authorize:

Name of Hospital/FACILITY/PHYSICIANS : _____

CITY, STATE: _____

TEL: _____ FAX: _____

To Disclose to:

COMPREHENSIVE PAIN MANAGEMENT
3811 E. Bell Rd., Ste. 207, Phoenix, AZ 85032
Tel: 602-971-8200 Fax: 602-971-8201

OTHER:

FACILITY/PHYSICIANS NAME: _____

CITY, STATE: _____

TEL: _____ FAX: _____

RECORDS BEING REQUESTED:

IMAGING REPORTS

ALL RECORDS (DOS RANGE: _____ THRU _____)

PAST ___ MONTHS OF OFFICE NOTES

OTHER: _____

I HEREBY AUTHORIZE THE ABOVE FACILITY TO PROVIDE RECORDS TO THE REQUESTED ENTITY. THIS AUTHORIZATION SHALL EXPIRE 1 YEAR FROM THE DATE THIS AUTHORIZATION IS SIGNED.

AUTHORIZED SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP IF NOT PATIENT: _____