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

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: _____