CENTER FOR PAIN MANAGEMENT S.C.
7235 W. APPLETON AVE.
MILWAUKEE, WI 53216
PHONE: 414-444-8670
FAX: 414-444-8678

AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize the use/disclosure of my health information as described below. I understand that a photocopy or fax of this authorization is as valid as the original.

Patient name: _____ Date of birth: _____

I authorize the release of my information __from / __to Center for Pain Management __to / __from:

Physician: _____
Address: _____
Phone: _____
Fax: _____

- PLEASE NOTE THE ABOVE INFORMATION **MUST BE COMPLETE** OR THERE WILL BE A DELAY IN YOUR RECORDS BEING SENT

__Spouse: _____
_ Other: _____

Information that may be used / disclosed: (please check all that apply)

__ Entire Medical Record _____
__ Records of visits (specify) _____
__ Other: _____

This authorization will expire:
_ 1 Year from today's date
_ Until further notice
_ Other
Administrative fee's apply please call to inquire.

_____ _____
Signature of Patient or Representative Today's Date

_____ _____
Printed name of patient or Representative Today's Date