

**LAST NAME**   **FIRST NAME** **M.I**\_\_\_\_\_\_\_\_\_

**D.O.B**  \_\_\_\_\_\_\_\_ **SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MAILING ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY** **STATE** **ZIPCODE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CELLPHONE** **HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PREFERRED METHOD OF CONTACT**

TEXT EMAIL PHONE CALL

**GENDER** M F **MARITAL STATUS**  S M D W  **PCP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RACE**

**AFRICAN AMERICAN OR BLACK HAWIIAN ASIAN**

**AMERICAN INDIAN OR ALASKAN NATIVE HISPANIC CAUCASIAN**

**AMERICAN INDIAN OR ALASKAN NATIVE**

**EMERGENCY CONTACT NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELATIONSHIP** **PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



I authorize the following person(s) full access to my entire medical information at Comprehensive Pain Care, in compliance with HIPAA regulations. I may change this at any time in person at my request. I understand that this will remain in effect for 1 year, at that time I will fill out a new one.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

****

Medical Records Release Form

**I hereby authorize COMPREHENSIVE PAIN CARE to obtain the following protected health information on my behalf, for the duration of my care with them. I understand that I have the right to revoke this authorization at any time. I understand that revocation will not apply to information that has already been released in response to this authorization.**

**From:**

1. **Facility’s Name**
2. **Facility’s Name**

**I HEREBY AUTHORIZE YOU TO RELEASE THE FOLLOWING MEDICAL RECORDS**

* **Radiology Reports Laboratory Results**
* **Office notes Discharge summary**
* **Complete Records Procedure notes**

**TO:**

**Comprehensive Pain Care**

**201 N. Slemons**

**Monticello, AR, 71655**

**870-224-4545 Phone**

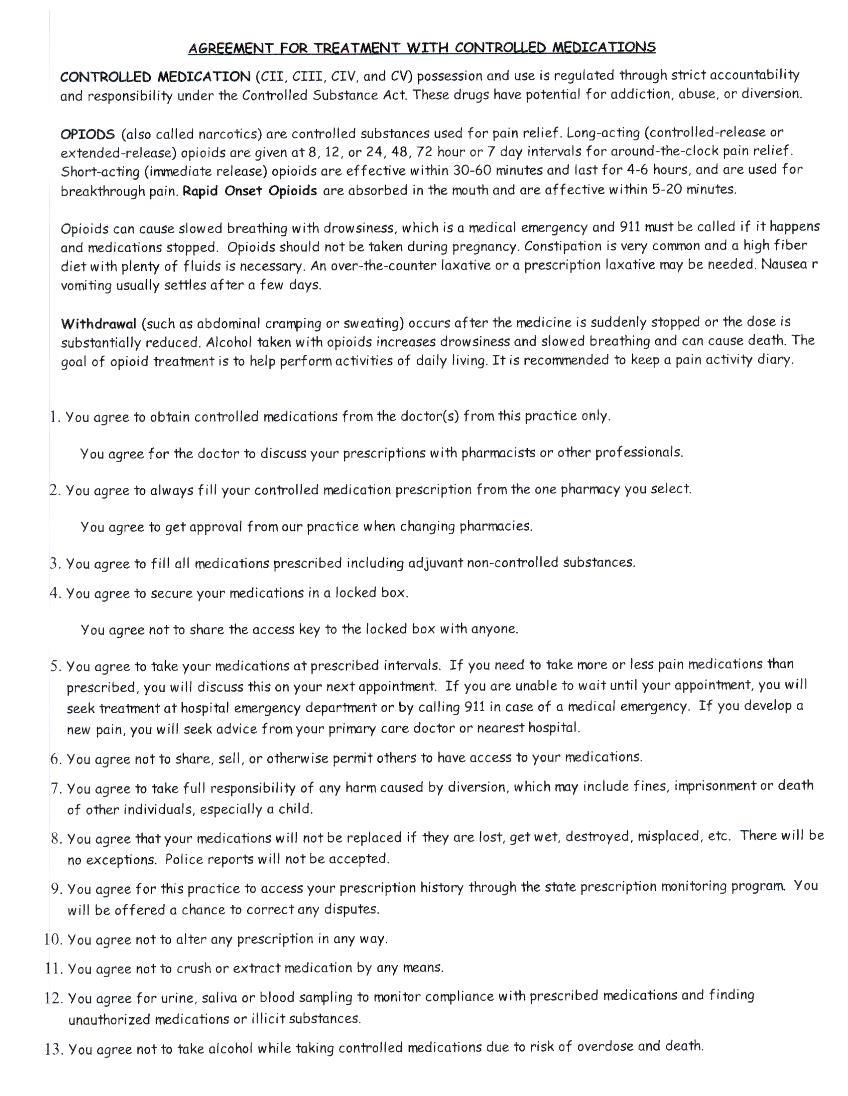
**866-809-4272 Fax**

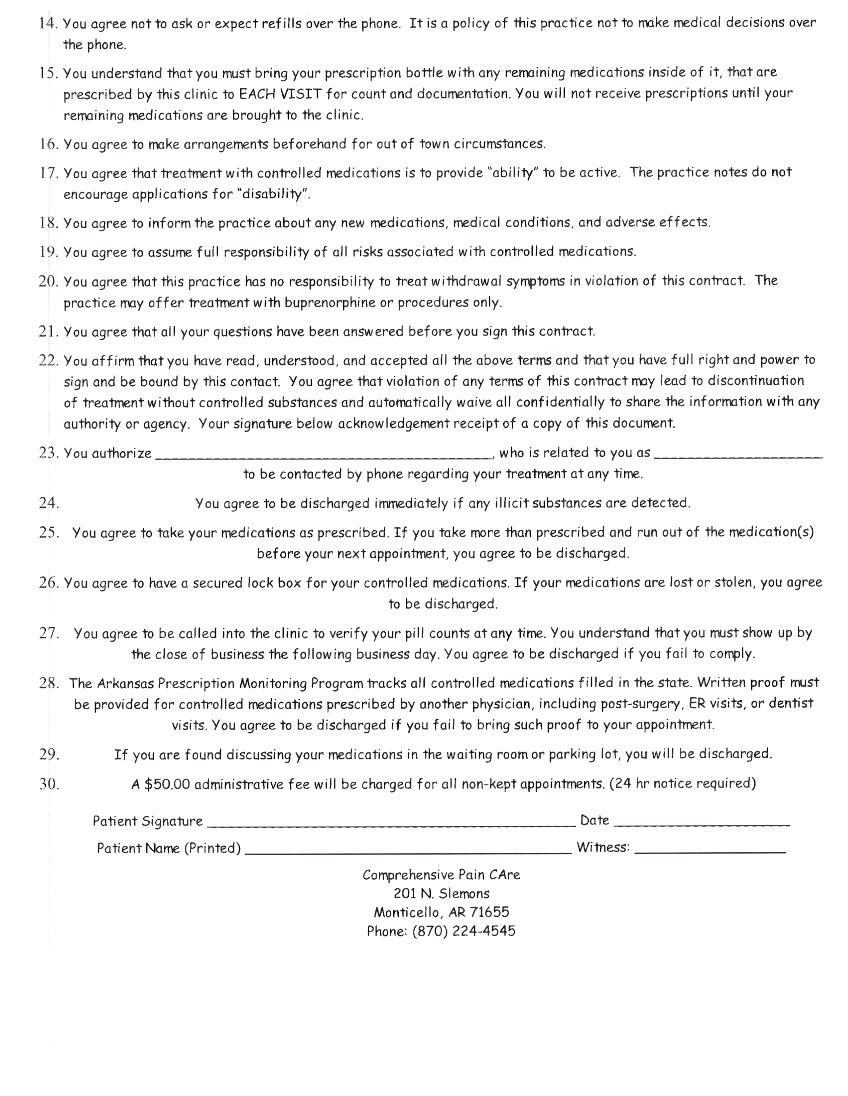
**CONSENT TO REMAIN IN EFFECT WHILE UNDER OUR CARE**

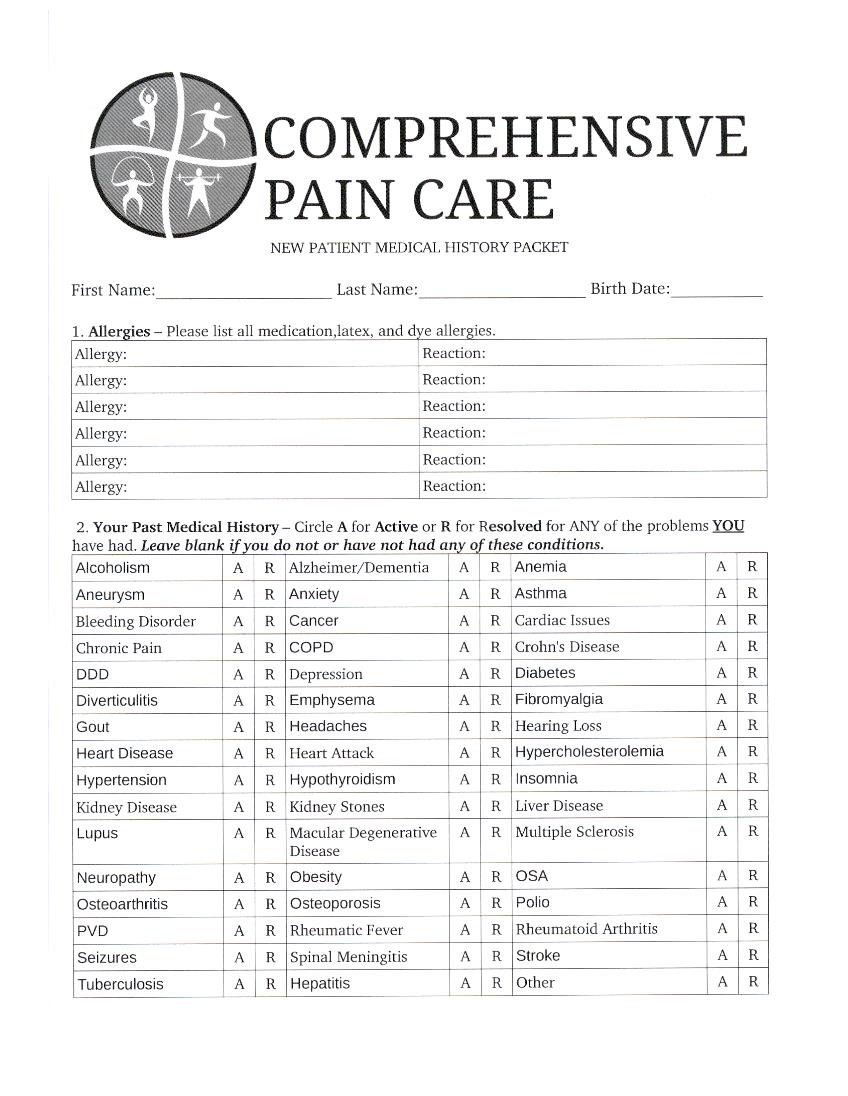
**(todays date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

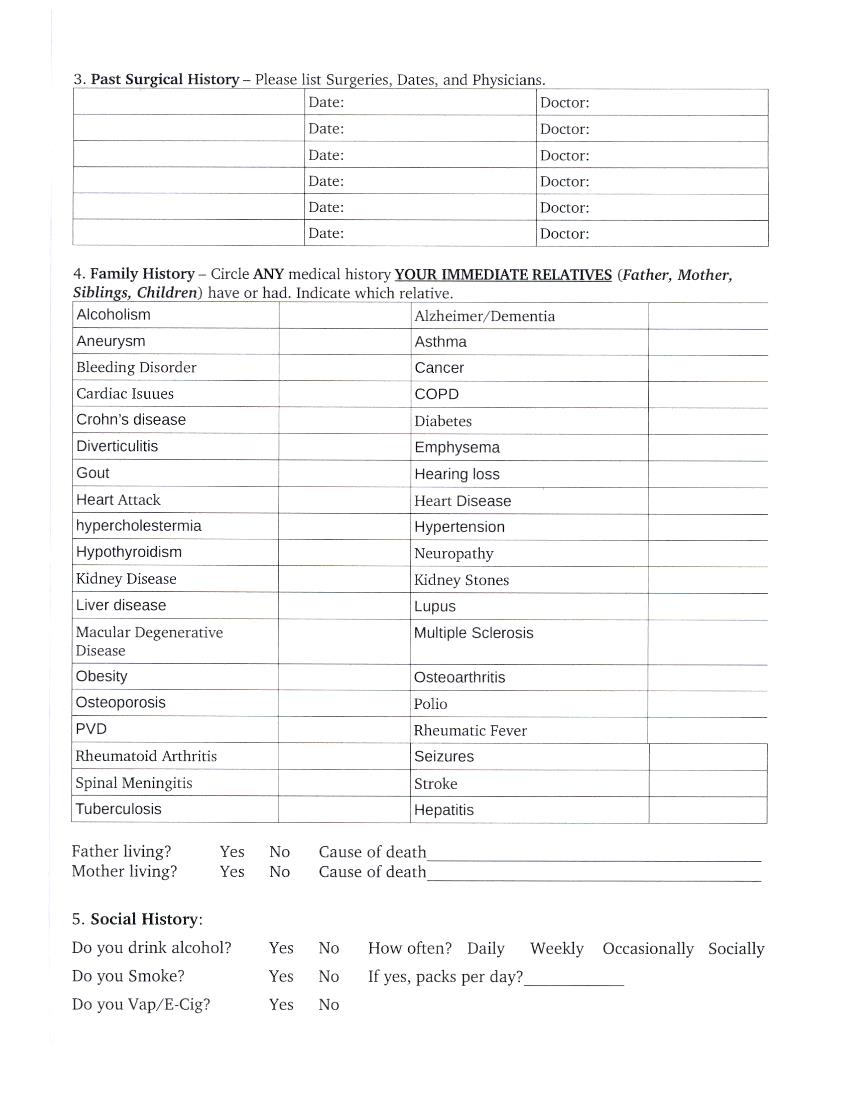
**PATIENTS NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

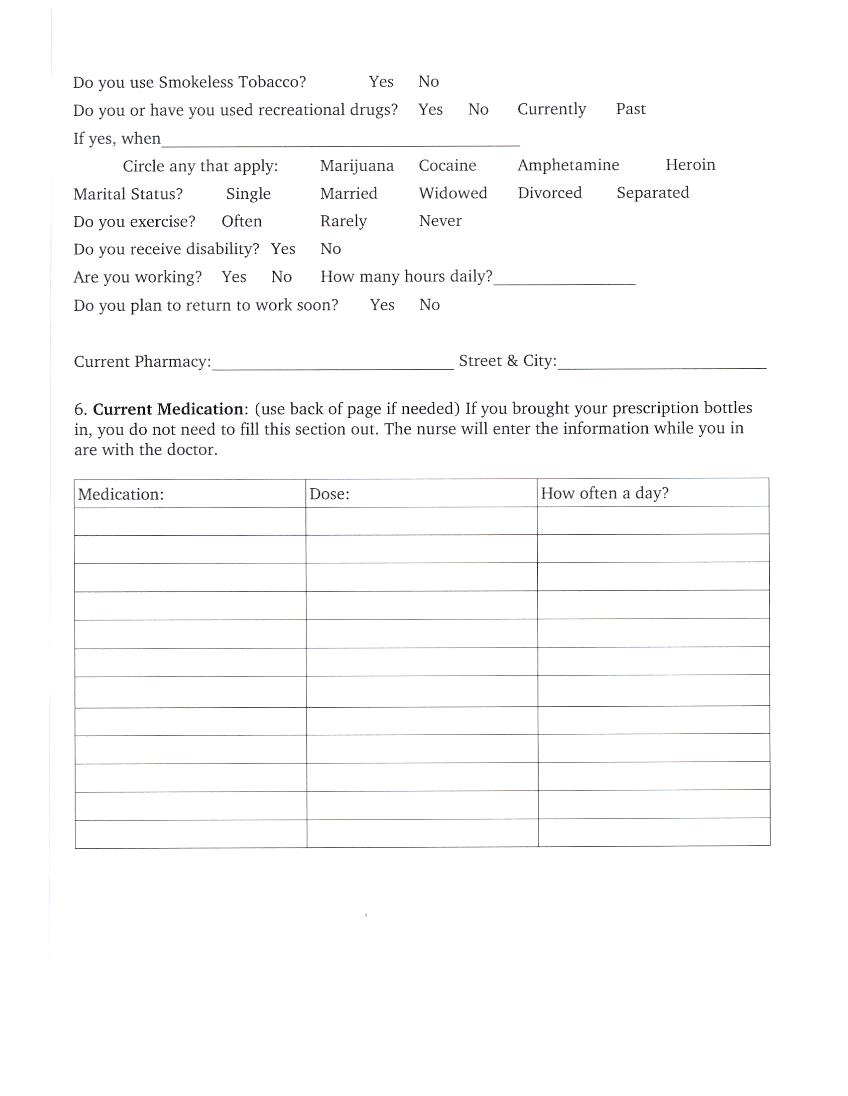
**PATIENTS SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

****

****

****

****

****

