COMPREHENSIVE PAIN MEDICINE; SANFORD M. SILVERMAN, MD, PA
100 EAST SAMPLE ROAD, SUITE 200
POMPANO BEACH, FLORIDA 33064
954-545-0106
FAX 954-545-0107

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL RECORDS

I hereby authorize **Comprehensive Pain Medicine; Sanford M. Silverman, MD, PA** to receive/ release medical records and data pertaining to:

Patient Name:	Social Security #:
Date of Birth:	Phone Number:
Street Address:	City, State, Zip Code:

Please specify what records should be released/ received.

- All records
- All records between the dates of _____ and _____
- Records pertaining to _____
-

For the purpose of:_____

Please specify method or release:

- Pick-up
- Mail
- Fax

_____I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office.

_____I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and the office will not base my treatment, payment or eligibility for benefits on whether or not I provide authoirzation for the requested use or disclosure.

_____I understand that the office will release only the minimum amount of information necessary to fulfill a request.

Unless otherwise revoked, this authorization will not expire.

Patient Signature:_____ Date:_____

FACILITY NAME, PHONE & FAX NUMBER	ADDRESS