

DISCLAIMER:

Filling out this form and emailing to the physician does not create a physician patient relationship until the patient is physically seen by the physician.

PATIENT NOTE: If you have not signed a form in your referring physician's office to release copies of your medical record to us, **please complete the release statement below and forward to your referring physician's office as soon as possible.** We must have copies of your medical record *before* your new patient visit.

RELEASE

I authorize my physician to forward any medical information deemed necessary for my medical care to Commonwealth Pain Specialists, LLC. I authorize the mailed, electronic or faxed submission of medical records.

Patient Signature

Date

Patient Name (please print)

Social Security #



Dear Physician's office,

This form is designed to allow you to release records to our office in support of the HIPAA privacy rule. Please forward the patient's records as quickly as possible for the new patient appointment. [Fax Number is 804-288-7245].

Thank you,

Commonwealth Pain Specialists