CONSENT TO DISCLOSE MEDICAL INFORMATION

☐ CC4PM-SYLVANIA ☐ CC4PM-BAYSIDE ☐ WCSC-CENTRAL AVE ☐ WCSC-Bayside

PATIENT NAME:_______________________________________DOB:___________________________

In order to better serve you, Comprehensive Centers for Pain Management, West Central Surgical Center, and West Central Surgical Center Bayside need to know what type of messages we can leave on your voicemail. Please indicate your preference for contacting you by phone.

CC4PM, WCSC, WCSC- Bayside has my permission to leave a detailed message on my answering machine/voicemail.

Agree _____ Disagree______ Other____

If you disagree, we will leave enough information for you to call us back.

CC4PM, WCSC, WCSC- Bayside will always leave detailed information when confirming your appointments, unless otherwise indicated by you, the patient.

Agree _____ Disagree ______

If you disagree, a message to call us back will be left on your answering machine/voicemail.

Who may we speak to concerning your Protected Health Information?

Please indicate any other people with whom we are allowed to disclose or discuss your Protected Health Information. Please check the types of information you authorize CC4PM, WCSC, WCSC-Bayside to disclose/discuss with indicated family/friends:

____ Relationship__________________________

____ Relationship__________________________

☐ My entire file___or more specifically: (Please indicate below)

☐ Diagnosis ☐ Progress to Date ☐ Dates of Treatment ☐ Clinical Psychologist
☐ Prognosis ☐ Billing Information ☐ Treatment Plan ☐ Symptoms
☐ Test Results ☐ Modalities & Frequencies of Treatment Furnished Other__________________________

I understand that I may revoke or change this authorization at anytime by completing another Consent to Disclose Medical Information form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that I have the right to receive a copy of this authorization, if requested. I understand that this authorization will not expire.

Patient Signature:____ Date:________________________