

AUTHORIZATION FOR COMMUNICATION

San Diego Pain Medicine
9834 Genesee Ave. Ste 312
La Jolla, Ca 92037
Phone: (858) 453-7128
Fax: (858) 453-3915

Today's Date _____

I hereby authorize communication regarding my care, between Dr. R. Lee Wagner and the Person/Persons named below:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This release will expire one year from the date above. I understand that I have the right to limit the type of information released. If I choose to limit the information released, I understand that it may be necessary for San Diego Pain Medicine to inform the requestor that portions of the medical record have been withheld. Indicated below is any information that is not to be released. Medical care providers also retain the right and responsibility to withhold releasing information that may be detrimental to the welfare of the patient.

This consent may be revoked at any time by the undersigned by written notice except to the extent that action has already been taken or is required by law. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above. I understand that I am under no obligation to sign this authorization and that agreeing or declining to sign this form will not affect my care at San Diego Pain Medicine. I understand that SDPM has no control over my information once it leaves their possession.

Patient Name (PRINT): _____ DOB: _____

Patient or Responsible Party's Signature: _____

Relation to Patient: _____