Authorization to Release Medical Records

I, _____ authorize the following person or organization, _____, to mail or fax my medical records to:

PHYSICIAN PAIN CARE
9898 Highway 92, Suite 100
Woodstock, GA 30188
Phone: (770) 516-7880
Fax: (770) 516-7870

I understand that this information will include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care and evaluations, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should not be released: _____

I understand that I may revoke authorization of consent at any time except to the extent that action has previously been taken in reliance thereof.

Patient Signature _____ Date of Birth_____

Printed Name _____ Date _____

Witness_____

This form is valid for one year from patient signature date