Centers for Pain Management, LLC
1493 Kennedy Road, Suite B
Tifton, Georgia 31794
(229) 391-2910 Telephone
(229) 386-4770 Fax

_____
Name of Patient

_____
Address:

_____
Date of Birth:

_____
Social Security Number

To: _____

The undersigned hereby authorizes and requests the release of the following information to:
Centers for Pain Management
_____M.D.
Any information including diagnosis, medical history, examination reports, any treatments rendered, lab results, x-rays, mental health evaluations, hospital records and reports, surgical reports, prescriptions and any other protected health information.
Specifically
include:_____

Initial in the space below:
_____ I am aware that my records may contain information concerning AIDS /HIV and that this will be included in the information released.

Purpose for Need of Disclosure
_____ At the request of the individual
_____
_____

_____ _____/_____/_____
Signature of person giving consent Date
(if not the patient please state relationship to patient)

_____

Information Released by _____ Date Released _____/_____/_____